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Evaluation of the functions and organization of the mental hygiene program in Montana

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AN EVALUATION OF THE FUNCTIONS AND ORGANIZATION OF THE MENTAL HYGIENE PROGRAM IN MONTANA

by

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CHAPTER I

THE PROBLEM AND DEFINITIONS OF TERMS USED

The problem of mental health gained recognition as a national health problem by the passage of the Mental Health Act, 1946. The Act provided for a three-way attack upon the problem of mental health in the three areas of Community Services, Research and Training. By providing federal assistance and consultative services, the Act gave impetus to the establishment of individual state programs and the Montana program was established in 1947. This study has examined the organization and structure of the Montana program.

I. THE PROBLEM

Statement of the problem. At the present time, the case load among the four clinics in Montana is not commensurate with the limited number of trained personnel. This situation has been shown by the lists of people waiting for treatment, and the situation has resulted in inadequate service. An analysis of the mental hygiene program will serve as a basis for evaluating clinic organization and policies.

It was the purpose of this study (1) to evaluate the Montana program by the standards set up by the Community Services Committee of the National Advisory Mental Health Council, (the state personnel policies were examined according to the standard set up under the State Merit System), (2) to evaluate the "open door" policy in Montana by the results of the referral policy at the Prince Georges County Mental Health

Clinic, Maryland, where experiments were conducted in "intake procedures," (3) to evaluate the best use of clinic personnel time and training by examining the functions of "traveling clinics" and the work of local Mental Health Societies.

Use of the study. It is assumed that a study of the mental health facilities in Montana has value since the "waiting lists" indicate that the demand for services cannot be met adequately by the present personnel.

There is value in understanding the programs of other states. This knowledge is significant since the passage of the Mental Health Act, 1946, led to the establishment of state programs.

Since program planning within the State is in a constant state of flux, there should be a continuous evaluation of needs and policies of the program in order to improve present services.

A significant factor which indicates the necessity of additional research, is the fact that there is no printed material in Montana regarding the state program.

Procedure. This study has traced the development of the Mental Health Movement, which led to the passage of the Mental Health Act, and the ultimate establishment of state programs. The emphasis of the study has been in the three areas of Research, Training and Community Services, and the examination of the Montana program has been the focal point of the study.

II. DEFINITION OF TERMS USED

Intake policy. This policy means that at the time of a patient's initial contact with a clinic, screening is done to determine the best possible arrangements for the patient regarding his problem. The

"Open Door Policy" is followed in Montana, whereby anyone is eligible for clinic services regardless of his age or the nature of his problems. The "Fee Charging Policy" is used in some states to defray the cost of mental hygiene programs by charging a nominal amount to patients for the services they receive.

Traveling Clinics. The purpose of traveling clinics is to make psychiatric services available to rural areas by enabling team members to carry their services to outlying areas.

Mental Health Societies. These organizations of lay people sponsor community projects and disseminate information to the community regarding psychiatric problems.

CHAPTER II

THE HISTORICAL BACKGROUND OF THE MENTAL HEALTH MOVEMENT

In order to understand the function of mental health facilities, one must examine the trend of thinking about mental illness from Colonial days in America. Significant movements and events will be presented which have had a bearing upon the development of the modern day standards of treatment.

The thinking in Colonial America reflected the harsh and ignorant attitude of seventeenth century Europe. This punitive attitude and some characteristics of early America prevented a well-integrated system of social welfare. First, the struggle for existence in a sparsely settled area caused the strong to band together against the weak. This factor caused the sick individuals to be at the mercy of a harsh society. Secondly, the Puritan belief that a stern providence punished the inferior person caused the responsibility for care to be placed upon the individual. This unsympathetic belief caused people to be "disposed of" rather than to be helped. Third, the rigors and isolation of the primitive environment discouraged trained medical men from practicing medicine in the new states.[1] The resultant action of such conditions meant that ill persons were either punished by such methods as racks and gallows, or were repressed by imprisonment.

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[1] Albert Deutsch, The Mentally Ill In America (New York: Columbia University Press, 1946), p. 58.

In addition to the rugged existence, the Industrial Revolution of the seventeenth century caused overcrowded conditions in the poor-houses. This condition ultimately led to the crusade in the 1840's by Dorothea Dix. Her fight became nation-wide, when in 1848, she aimed for the following: A petition to Congress urged that body to grant to the states, on the basis of population, 5,000 acres of land, the proceeds of the sales to be used exclusively for bettering the condition of the indigent insane.[2]

Although the bill was vetoed because the federal government felt that it could not become involved in granting aid for a humanitarian cause, it pointed out the responsibility of the state-operated hospitals toward their patients.

Another significant move occurred in 1693, when Governor Phipps of Massachusetts issued a proclamation which released from custody all persons confined in prison on witchcraft charges.[3] This action eliminated some of the superstition and consequent persecution of the "insane" and was significant in placing the care of the sick in the hands of society.

The crusade by Dorothea Dix in the middle 1800's and the proclamation of Governor Phipps illustrated a revolt against hearsay and ignorance. Although progress in the field of mental health often met with retrogression, there was, nevertheless, a gradual enlightenment about the illness.

In the eighteenth century, the person most responsible for

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[2]Ibid., pp. 28-32.

[3]Ibid., pp. 38-42.

dispelling the fear of psychiatric treatment was Benjamin Rush, "The Father of American Psychiatry." His major contribution was raising the study and treatment of mental illness to a scientific level, by his attempts to systematize the subject.[4] The progress of the nineteenth century can best be shown by his proposal of reforms which include the following:

1. The erection of separate buildings to house those in a "high and distracted state of madness" in order to protect others from unhealthy reactions and loss of sleep.
2. The introduction of labor, exercise and amusements for the patients "which shall act at the same time upon their bodies and minds."
3. Separation of the sexes.
4. The hiring of an intelligent man and woman to attend the different sexes, and to share their activities.
5. The rigid exclusion of all visitors—even near relations—likely to have a disturbing effect on the patients.
6. Furnishing the cells of pay patients with feather beds and hair mattresses.[5]

Although the reforms of Benjamin Rush were of a rehabilitative nature, they centered entirely around hospitalization. Since there was not much emphasis given to out-patient care and treatment, the major consideration was given to the financing and organization of institutions. Nevertheless, the ground work laid by such leaders as Dorothea Dix, Governor Phipps, and Benjamin Rush caused medical superintendents to become aware of some of the problems of hospital patients.

Other outstanding men in the development of better mental health practices include Dr. Samuel B. Woodward of Worcester State Hospital in Massachusetts who in 1844 organized a group of physicians to advance the interests of the mentally ill. Among this group were Dr. Pliny Earle who

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[4] Arthur Hiler Ruggles, Mental Health Past, Present and Future, (The Williams and Wilking Company, 1943), p. 6.

[5] Ibid., p. 68.

helped to eliminate some of the ignorance by his critical, analytical study of hosptial records and statistics; and Dr. Isaac Ray who published a treatise on mental hygiene which outlined a program for prevention.

The reforms of the nineteenth century, together with the influx of population, increased the number of poor-houses and hospitals. This situation necessitated a shift from local to state responsibility, together with the following advantages:

> By investing supervisory powers in a central authority, a potent check could be raised against abuses, and a greater degree of uniformity in operation of charitable institutions could be attained.[6]

In summary, the major contributions of the nineteenth century were improved institutional care, state supervision of the mentally ill, and the enlightenment of psychiatric knowledge. These significant contributions caused the emergence of psychiatry from its isolation in the community.

The progress toward better treatment of the mentally ill begun by these far-sighted men of the nineteenth century was continued by great leaders of the present century. One of these was Dr. Adolf Meyer, who saw "mental disorder as a maladjustment of the whole personality rather than as a brain disease in the purely physiological sense."[7] His thinking led to an emphasis on individual and comprehensive records for psychiatric patients.

Another leaders, Emil Kraepelin, the last and great of the descriptive psychiatrists, introduced a system of classification of mental diseases. He introduced the term "functional" as different from the organic diseases.

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[6] Deutsch, op. cit., p. 247.

[7] Deutsch, op. cit., p. 287.

His thinking "provided a valuable key to the understanding of the what and how in mental disorder, but the greatest question—the why—still remained wrapped in mystery."[8]

During the time that Kraepelin was making his observation, Sigmund Freud, a Viennese physician, propounded the theory of psychoanalysis based upon "free association." Although there is controversy regarding Freud's theories, psychoanalysis has proved beneficial in the treatment of neuroses. Dr. Eugene Bleuler helped to put psychoanalysis on a practical basis in psychiatric treatment.

Significant movements followed the reforms of the past centuries and laid the groundwork for the mental hygiene movement which was founded by Clifford Beers. Beers, a patient in a mental institution for six years, wrote an impressive autobiography of his experiences. Beers' book entitled, The Mind That Found Itself, was the forerunner of the mental hygiene movement.

The movement culminated in the founding of the National Committee for Mental Hygiene in 1909. The primary task of the organization was to initiate a survey of existing mental hygiene facilities in the United States. In addition to the movement's gaining recognition in local communities, it increased in strength until it became internationalized in 1936. The First International Congress on Mental Hygiene was held in Washington, D. C. and was attended by more than three thousand persons representing fifty countries. The purposes of the Congress were as follows:

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[8]Deutsch, op. cit., p. 407.

[9]Ibid., p. 316.

1. To bring together from all countries—workers in mental hygiene and related fields for exchange of information and experience, and for mutual consideration of individual and social problems growing out of nervous and mental disease.
2. To consider ways and means of world cooperation and of more effective promotion of mental hygiene in the various countries.[10]

The Mental Hygiene Movement and the adjustment of soldiers of World War I caused the convergence of the professions of psychiatry and social work. The psychiatrists needed trained social workers who could interpret the environmental factors in mental breakdowns, and the social workers were concerned with the effect of "personality" in the treatment of socially maladjusted individuals.

With the linkage between social work and psychiatry, it was inevitable that mental hygiene aspects would be significant in the Child Guidance Movement of 1922. The advent of the movement came partially as a result of surveys conducted among school children in the large schools of Maryland and Virginia. The results of the survey showed:

1. Many behavior problems existed among apparently normal children attending public schools.
2. Facilities for dealing with these problems were grossly inadequate.[11]

The establishment of clinics with trained personnel was the answer to working with children with behavior problems.

Like the child guidance clinic, the prison clinic developed out of the extension of mental hygiene to the field of delinquency. The pioneer clinic was founded at Sing Sing, and was followed by the establishment of similar clinics in other correctional institutions. The advantages of

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[10] Deutsch, op. cit., p. 329.

[11] Ibid., p. 316.

adequately staffed clinics in penal institutions are assisting prisoners to adjust to prison life, and giving individual treatment to those who can benefit from it.

Although this chapter has shown how outstanding men and movements have been significant in furthering the cause of mental health, the three most prominent personalities in America have been Benajmin Rush who made lasting efforts to raise the study and treatment of mental illness to a scientific level; Dorothea Dix who helped to humanize the treatment of the insane in the hospital setting; and Clifford Beers who brought about a coordination of scientific and human reforms by his efforts toward organized mental health.

The Mental Health Movement increased the public's concern about the problem of mental health and people became aware of the scope of the problem. There are at present nearly three fourths of a million people under the care of mental hospitals and this number represents more than half of the number of patients in all hospitals for all diseases in the entire country.[12] On any given day, 750,000 of the mentally ill fill every available hospital bed.[13] This situation has led to overcrowded conditions and insufficient trained personnel. The federal government estimates that at least 330,000 more hospital beds are needed. In addition to the shortage of beds and hospital space, the average state mental hospital has only one doctor for every ten that it needs.[15]

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[12] Facts About Mental Illness (New York: The National Association For Mental Health, Inc.), June, 1954, p. 33.

[13] Sam Slavinsky, National Business, (New York: Commonwealth Fund) July 1955, p. 87.

[14] Facts About Mental Illness, op. cit., p. 59.

[15] Ibid., p. 64.

The number of hospitalized patients and the shortage of facilities became apparent following World War II. Of the 15,000,000 men examined under selective service procedures, about 856,200 were rejected for neuro-psychiatric disorders.[16]

In addition to the number of rejectees, there are many intangible results of service which have affected the everyday activities of the soldier.

In addition to hospitalized patients, more than 200,000 persons are treated annually at clinics available in some 1,150 areas of the United States.[17] One reason that the figures are not higher in regard to out-patient treatment is the fact that treatment is available to relatively few. At the present time there are only about six hundred full-time clinics in the entire country and an additional six hundred part-time clinics which give service one or two days a week.[18]

Recognizing that the problem of mental health is of such magnitude that extraordinary measures were necessary, in 1946, Congress passed the National Mental Health Act. The Act authorized the federal government to participate in a comprehensive program designed to prevent mental illness and to promote more positive mental health among the general population. The legislation is based on the concept that public health techniques which have reduced the hazards of physical health can be adapted to a large-scale, nation-wide attack upon mental, emotional and nervous disorders.

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[16] James, Lowry, "Mental Health," Social Work Year Book, 1951, pp. 45-46.

[17] Deutsch, op. cit., pp. 487-488.

[18] Facts About Mental Illness, op. cit., p. 86.

THE NATIONAL MENTAL HEALTH ACT

The National Institute of Mental Health was established in April, 1949 as one of the six institutes which comprise the National Institute of Health research arm of the Public Health Service.

Figure I illustrates the various institutes which are under the National Institute of Health. The Division of Research Grants and the Clincial Center are available for the six institutes and make possible comprehensive studies involving more than one area of health.

The creation of the organization represented the expansion of an existing service rather than the development of a totally new one. To assist in developing the program, the Act provided that a National Advisory Mental Health Council consisting of six outstanding medical and scientific leaders in the mental health field to be appointed by the Surgeon General of the Public Health Service. The Council makes recommendations to the Public Health Service on all matters relating to mental health and has committees that are authorized for consultative work in various communities where mental hygiene facilities are established or needed.

The purpose of the National Mental Health Act according to law is as follows:

> The improvement of the mental health of the poeple of the United States through the conducting of researches, investigations, experiments, and demonstrations relating to the cause, diagnosis, and treatment of psychiatric disorders; assisting and fostering such research activities by public and private agencies, and promoting the coordination of all such researches and activities and the useful application of their results; training personnel in matters relating to mental health; and developing, and assisting states in the use of the most effective methods of prevention, diagnosis and treatment of psychiatric

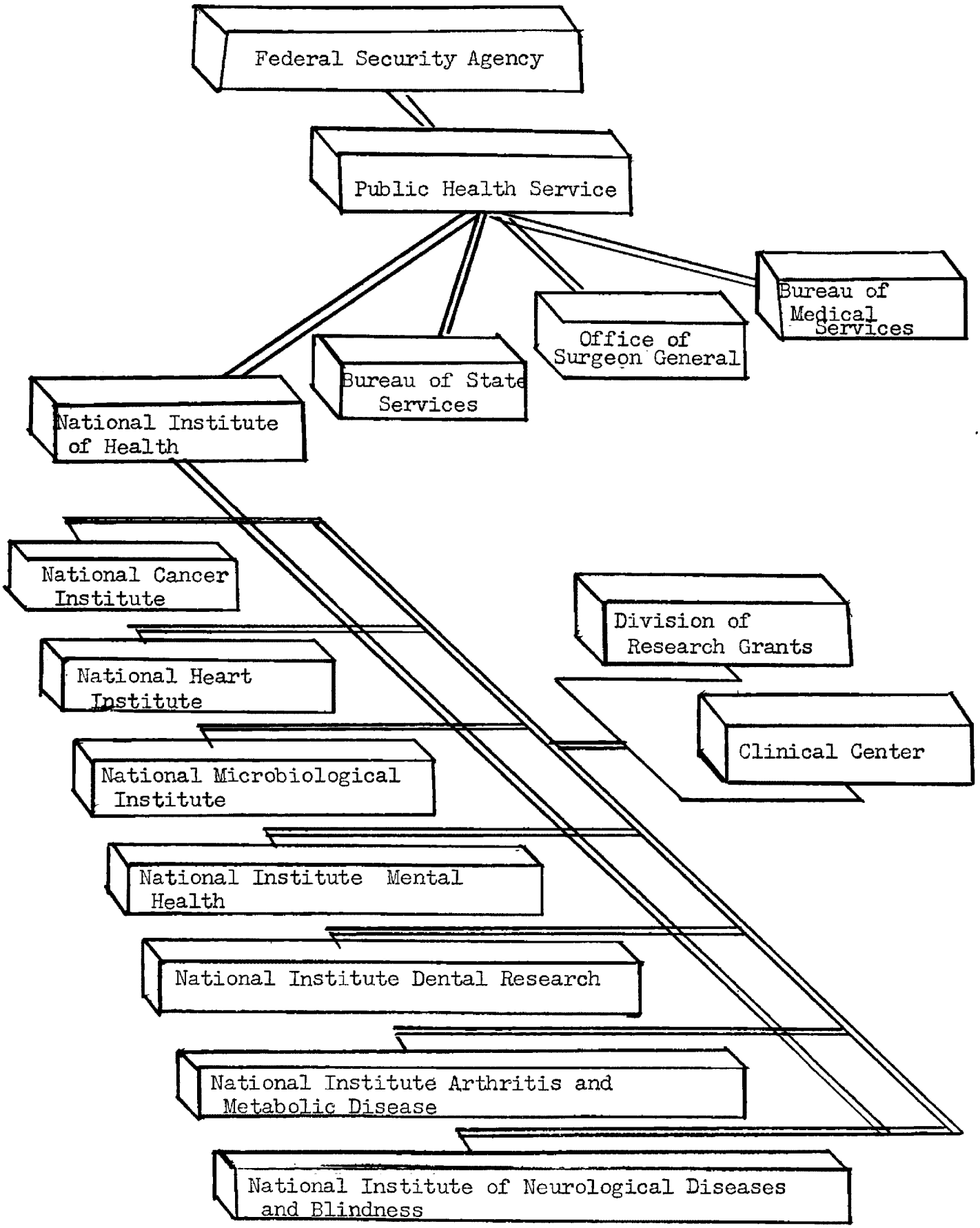

FIGURE 1

INSTITUTES OF THE PUBLIC HEALTH SERVICE*

*Public Health Service Pub. No. 20, (Washington: Government Printing Office, 1954)

disorders.[19]

It is apparent from the purpose of the program that in order to meet the total problem it must be attacked in several areas.

The act is aimed at bringing about direct action in three interrelated fields of (1) research, (2) training, and (3) community services.

I. RESEARCH

Organization. The Act provides for increased research in nervous and mental disorders. It recognizes that there must be research to discover the causes of mental illness, to develop more effective diagnostic and treatment methods, to bring greater understanding of preventing emotional disorders, and to promote better mental health. "The challenge of our time is to advance as rapidly as possible the understanding of diseases that still resists the skill of Science."[20]

Three advisory committees were formed to aid the National Advisory Mental Health Council in developing each of these programs and the research committee includes representatives from the various sciences concerned with mental health.[21] Its members assist the Council in outlining policies on research and in recommending research grants to non-federal research institutions and individual investigators.

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[19] Legislative Session, National Mental Hygiene Committee, Public Law No. 487, National Mental Health Act, January, 1945 (Washington: Government Printing Office). Sec. 2. 1951.

20. Report of the President's Scientific Board, Vol. V. (Washington: Superintendent of Documents, Government Printing Office)

[21] Mental Health Series, No. 4. (revised). National Institute of Mental Health, (Washington: Superintendent of Documents, Government Printing Office), 1950.

Clinic Laboratories. To provide opportunities for research, a Clincial Center has been established in the National Institute of Mental Health in the Washington area. Coordinated studies are conducted at the Center and the patients are selected for study on the basis of suitability for understanding a particular disease. The Center provides the closest possible cooperation between the research laboratory and the clinical personnel who care for, treat, and observe the patients. The Institute's program of clinical study is carried on in various laboratories.

Laboratory For Child Research. In this laboratory studies are conducted on the diagnosis, treatment and prevention of the emotional disturbances which produce severe behavior problems in children. The laboratory staff, which has been trained in various areas of mental health, collaborates in the treatment of children.

Laboratory of Adult Psychiatric Investigations. This program is directed toward the intensive study and treatment of mental illness with a view toward understanding the cuasative factors. Attempts are also made to develop new methods of treatment and to test ways in which current therapeutic methods can be improved.

Laboratory of Psychology. The work in this laboratory centers around the various areas of child behavior and development. Much experimentation is carried on in this laboratory and the findings are used by personnel working in the other branches of research.

Laboratory of Psychosomatic Investigations. This program is concerned with the part played by emotional factors in disorders of a physical nature.

In addition to the various areas of research conducted by the

National Institute of Mental Health, Public Health Service grants are made available to assist the research efforts of qualified investigators throughout the country. The grants program, together with financial support from foundations, makes a significant contribution in the field of mental health.

The objective of the mental health research grants program is to assist scientists in universities and other research centers in their efforts to find answers to problems of mental illness.

Figure 2 demonstrates the procedure that is followed for applicants applying for grants. The applications must be reviewed by the National Advisory Health Council before they can be approved by the Surgeon General of the Public Health Service.

II. TRAINING

Organization. The second large aspect of the National Mental Health Act is in the area of training of personnel.

> The shortages of psychiatric personnel are so great that only all out efforts can even begin to meet needs. In all psychiatric and related fields there are too few training centers and teachers.[22]

At the present time, there is a shortage of trained people and additional personnel is needed for clinical positions, teaching, research, and administrative positions.

The Institute's training and Standards Branch is the organization selected to carry out the responsibility for training personnel. Its function is to improve the qualities of training and to increase the number of professional people employed in the mental health field. One

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[22]National Institute of Mental Health, Report of National Health Assembly, (New York: National Institute of Mental Health), May, 1949.

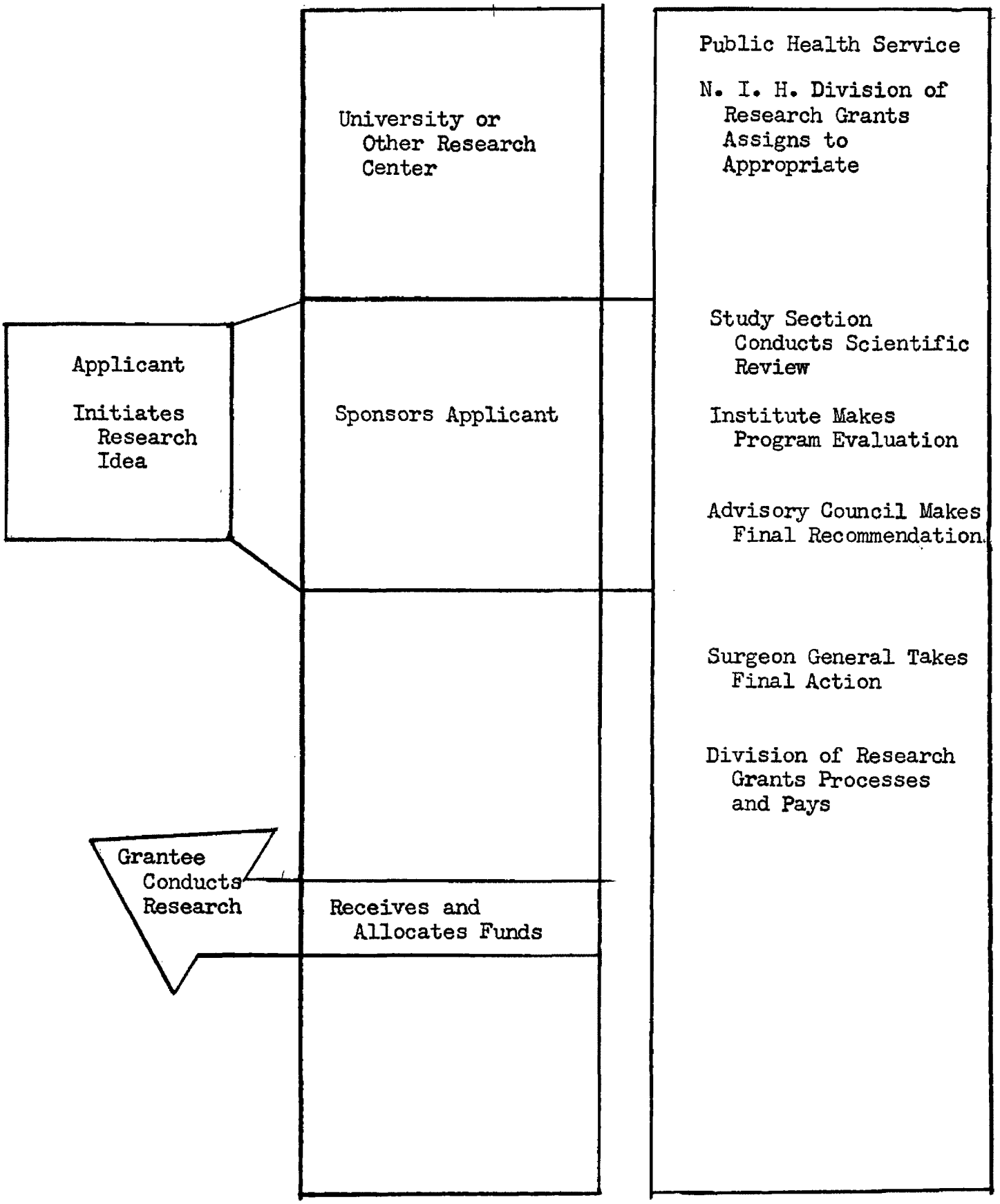

FIGURE 2
HOW A RESEARCH GRANT IS MADE

way in which the Institute supports training is through grants to universities and other centers for the purpose of strengthening the program. This branch is also responsible for seeking to improve the quality of training by supporting professional groups in the field. At times it also provides for grants to group organizations for conferences relative to mental health. The present training program of the Institute of Mental Health is a small, but it is significant beginning toward alleviating the shortage of personnel that characterizes all phases of the mental health program.

III. COMMUNITY SERVICES

Organization. The third category of mental health activity which the act promotes is the improvement of mental health services in local communities through grants-in-aid to states. It is through the development of community programs that efforts will be made to reach people who can profit by mental health services.

> The ultimate objective of the National Mental Health program is to help the individual by helping the community; to make mental health a part of the community's total health, to the end that all individuals will have greater assurance of an emotionally and physically healthy and satisfying life for themselves and their families.[23]

The program is organized so that in each state an agency designated as the "Mental Health Authority" is responsible for receiving and administering federal grant funds. Each state that is eligible for financial assistance must be able to match each two dollars of federal funds with one dollar of state or local funds. The funds are given to individual states for services according to their financial need, population, and the

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[23] Ibid., p. 35.

extent of the mental health problem. The staff of the Community Services Branch in Bethesda provides technical services and consultation services to the state programs.

In the total picture of mental health programs there are seven general areas in which the programs are active:

1. Development of staff
2. Education of professional groups
3. Community education
4. Clinical services
5. Consultation services
6. Rehabilitation services
7. Special studies[24]

Since many of the present state programs are in their beginning stages, there is much room for experimentation and study to improve and expand present state facilities.

In order to improve the present standards and methods of treatment among state programs, a demonstration project was established by the National Institute of Mental Health in 1948 in conjunction with the Maryland State Health Department in Prince Georges County, Maryland. The purpose of the program was to determine ways of making the best possible use of a local health department.

In order to understand the services rendered by the health department in Prince Georges County, one must know that one half of the staff's time is used in the treatment of individual patients and the remainder of the time is spent in providing consultation and services to the other division of the mental health department and the community. Some of the

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[24]National Institute of Mental Health, Public Health Service Publication No. 20 (Washington: United States Department of Health, Education and Welfare, 1952), p. 68.

studies conducted in that particular community deal with the study of record keeping, the selection of patients for clinic care, and methods of setting up a community mental health program. It is hoped that by a comparative study of state programs more adequate facilities will be developed.

It is hoped that the three-way approach to the problem as provided by in the National Mental Health Act will accomplish much toward improving the methods of treatment and increase the number of trained personnel.

CHAPTER III

THE SURVEY OF MENTAL HEALTH FACILITIES IN THE WESTERN AREA

There has been a gradual change in the attitude toward mental illness since Colonial days. The change in thinking has kept pace with the social, economic and political changes of the twentieth century. The recent advancements in the field of medicine and the incidence of mental illness has led society to recognize it as the "number one health problem." The recognition of the magnitude of the problem has led to the need for a concentrated program. This, in turn, ulitmately caused the passage of the Mental Health Act of 1946 which attacked the problem in the three main areas of research, training and community services. The Act focused state attention upon the problem by giving assistance in planning state programs and in providing financial and consultative help.

The consideration of the problem of mental illness was apparent in 1954 when the Western Regional Conference of the Council of State Governments requested the Council and the Western Interstate Commission of Higher Education to make a "region-wide survey of mental health training in the West."[1]

The Western legislators asked that special attention be given to

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[1]Western Interstate Commission For Higher Education, Mental Health Training and Research in the Western Region (Colorado: Western Interestate Commission For Higher Education, 1956), p. 1.

"preventive measures" and decided that an investigation be made for the following:

1. Identification and mobilization of all existing and potential facilities.
2. Augmentation and encouragement of those facilities that seem to bear most effectively on the problem.[2]

Organization. The Western Interstate Commission for Higher Education (WICHE) decided to use the questionnaire method of study and to include the western states of Arizona, California, Colorado, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, Wyoming, and the territories of Alaska and Hawaii. The results of the study were unique since the inclusive area covered one-third of the United States in land area and had one-sixth of the population. The planning committee felt that if the sampling was broad, opportunities would be provided for original suggestions for the prevention of mental illness.

The committee was faced with seeking information from many sources and it decided upon the following groups and professions:

1. Policy makers and legislators on the state level
2. Treatment and training centers
3. Mental health specialists—psychiatrists, pscyhologists, social workers, nurses—in all settings.
4. Social agencies both public and private
5. The general public as individuals and groups[3]

The committee decided that the mental health facilities should be explored in several areas including:

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[2] Ibid., p. 7.

[3] Ibid., p. 9.

1. Facts: what does exist?

2. Opinion: what are the causes of present conditions?

3. Suggestions: how can the situation be improved?[4]

The committee felt that by a wide coverage of people concerned with mental health problems and by use of the questionnaire method many strengths and weaknesses of present programs could be identified.

Because the questionnaire method included the wide coverage of both professional and lay people, it seemed to be the most valuable and practical. Although the state committees were aware of the limitations of the questionnaire method which would include misunderstanding of questions, and misinterpretation of information, the committee felt that it had value as an exploratory device for extensive coverage which was the objective of the survey.

It was decided that questionnaires should be sent to persons whose interests and activities might give insight into the scope of the mental health problem and who could offer some possible solutions to the problem. Questionnaires were sent to professional people in treatment and training centers and also to the general public and lay persons. People were included who were in the professions of law, the clergy, education, welfare agencies, and health agencies. It was hoped that a variety of viewpoints might be helpful in working out preventive programs for mental illness.

One attempt of this paper was to examine the problem of insufficient personnel in the three areas of research, community services, and training, as outlined by the provisions of the Mental Health Act.

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[4] Ibid., p. 9.

Community Services. In order to give psychiatric services to the people of Montana, the state should provide an incentive in encouraging people to come to the state. On the questionnaire concerning the advantage of the state, the largest number of respondents emphasized that pleasant climatic conditions and recreational opportunities made Montana an attractive place to be employed. Of the total number of respondents, 58.3 per cent of the group stressed the physical features of Montana as being appealing to employees. Of the eleven states included in the survey, 58.8 per cent of the respondents, including Alaska, felt that their states had appeal to professional workers. However, there were four states whose percentage of specialists responding was below that of Montana.

The next item checked in regard to frequency was that respondents find their jobs challenging in Montana. As shown in Table I, 22.2 per cent of the total number of respondents checked the item which might give indications that opportunities should be provided for personnel to help build a worthwhile program.

The third item that was checked by the greatest number of respondents concerned pleasant living conditions, inexpensive living, and friendly people. This item is somewhat closely related to the first item which stressed the physical attributes of the state. Again the appeal of the country and the people might be a consideration in developing a more adequate program. The items checked least frequently seemed to be those concerned with personnel policies and opportunities for training.

Of the total number of specialists who filled out the questionnaire, two and eight tenths per cent named the following facts as being an inducement to interest people in coming to Montana: (1) good state personnel

TABLE I*

PERCENTAGES OF MENTAL HEALTH SPECIALISTS NAMING VARIOUS FACTORS THAT MAKE THEIR STATES PARTICULARLY ATTRACTIVE TO PROFESSIONAL WORKERS IN THEIR FIELDS, BY STATE.
(Since a single respondent could cite several factors, the percentages do not add to 100.)

	State												
Factor making state attractive	Alas.	Ariz.	Cal.	Colo.	Ida.	Mont.	Nev.	N. Mex.	Ore.	Utah	Wash.	Wyo.	TOTALS
Pleasant climatic conditions; recreational opportunities, etc.	0.0	67.4	58.4	73.2	48.8	58.3	40.0	66.7	60.6	49.1	73.3	16.7	58.8
Good state personnel policies in terms of salaries, retirement, merit system, etc.	0.0	6.5	54.5	2.4	2.3	2.8	0.0	8.3	0.0	3.7	13.3	0.0	37.6
State is (or is becoming) "progressive" in treatment of patients	0.0	4.3	27.4	12.2	4.7	8.3	0.0	0.0	9.1	8.3	0.0	0.0	20.7
People of state are in general "progressive", e.g., in attitude toward respondent's profession	0.0	10.9	24.3	12.2	30.2	5.6	0.0	0.0	9.1	12.0	6.7	0.0	20.3
Good opportunities for advanced training and education	0.0	4.3	15.0	11.0	2.3	2.8	0.0	0.0	0.0	18.5	13.3	0.0	13.0
Good opportunities for advanced training	0.0	4.3	15.0	11.0	2.3	2.8	0.0	0.0	0.0	18.5	13.3	0.0	13.0

TABLE I (Continued)

Favorable employment or development opportunities in respondent's profession	0.0	21.7	11.5	13.4	2.3	13.9	20.0	25.0	21.2	18.5	6.7	50.0	12.9
Good state program in respondent's field	0.0	0.0	15.3	14.6	7.0	2.8	0.0	0.0	6.1	10.2	13.3	0.0	12.9
Pleasant living conditions; low cost of living, friendly people, sparse population, etc.	50.0	13.0	10.7	11.0	16.3	19.4	60.0	0.0	12.1	19.4	13.3	0.0	12.4
State presents a challenge to respondent or his profession	50.0	50.0	3.7	8.5	14.0	22.2	20.0	50.0	27.3	17.6	6.7	33.3	9.5
Professional standards are high in respondent's field	0.0	0.0	6.6	4.9	0.0	2.8	0.0	0.0	0.0	1.9	13.3	0.0	5.2
Active professional group operative in the state	0.0	6.5	3.4	6.1	2.3	0.0	0.0	0.0	3.0	4.6	0.0	0.0	3.6
Good interdisciplinary relations; lack of professional jealousy	0.0	0.0	2.9	4.9	7.0	2.8	20.0	0.0	0.0	1.9	6.7	0.0	3.0
Lack of regimentation and political interference	0.0	4.3	2.5	0.0	2.3	2.8	0.0	0.0	0.0	1.9	0.0	16.7	2.3

*Statistical Supplement to the Report of Mental Health Training and Research in the Western Region, June 1956.

policies in terms of salaries, etc., (2) good opportunities for advanced training and education, (3) a good state program, (4) high professional standards, (5) good interdisciplinary relations, and (6) lack of regimentation among the workers. Since a small percentage of the respondents felt that the program or personnel policies in the Montana program are outstanding, this might be an area for further study and consideration.

The only item that was not checked by a single respondent was that there is an active professional group in operation in the state. Without a strong professional organization in the state, it is difficult to have a well-coordinated program.

In addition to capitalizing upon the positive factors in Montana, the questionnaire provided opportunities for respondents to suggest changes that should be made in regard to the present program. Table II illustrates the suggested changes which should be made to add more incentive to workers. The item that was named most frequently was the one concerning a need for an increase in the salaries of professional workers. Of the total number of respondents, 54.8 per cent checked the item regarding salary increases. (This item corresponds with the second item on Table II in which only 2.8 per cent of the respondents felt that salaries were adequate.)

The second factor that was named according to frequency by the respondents was the improvement of opportunities for training and advanced work. Of the total number of respondents, 38.7 per cent (including research workers) named this factor as one that should be changed. (This response was similar to Table II in which only 2.8 per cent of the specialists felt that the Montana program offered good opportunities for training.

Of the number who returned the questionnaire, 25.8 per cent felt

TABLE II*

CHANGES THAT COULD BE MADE IN THE RESPONDENT'S STATE TO INCREASE ITS ATTRACTIVENESS TO PROFESSIONAL WORKERS IN THE RESPONDENT FIELD, BY STATE--AS REPORTED BY MENTAL HEALTH SPECIALISTS AND RESEARCH WORKERS IN MENTAL HEALTH.

(Figures show the percentage of respondents making each suggestion. Since a single respondent could give several answers, the percentages do not add to 100.)

Suggested change in state	State												
	Alas.	Ariz.	Cal.	Colo.	Ida.	Mont.	Nev.	N. Mex.	Ore.	Utah	Wash.	Wyo.	TOTALS
Increase salaries of professionals	0.0	30.0	34.3	61.0	41.9	54.8	60.0	22.2	33.3	45.5	54.7	40.0	38.5
Establish or improve mental health institutions and services	0.0	32.0	30.3	32.9	34.9	6.5	80.0	33.3	22.2	36.6	58.8	40.0	31.2
Improve opportunities for training and advanced work	50.0	52.0	27.8	19.5	7.0	38.7	20.0	17.7	36.1	24.4	23.5	0.0	27.3
Improve state personnel policies as to retirement, merit system, etc.	0.0	10.0	17.4	8.5	16.3	25.8	20.0	0.0	30.6	10.6	0.0	40.0	15.8
Create better acceptance of respondent's profession	0.0	30.0	15.6	7.3	9.3	6.5	40.0	11.1	8.3	9.8	5.9	20.0	14.2
Improve interdisciplinary and interinstitutional cooperation	0.0	4.0	10.6	22.0	2.3	19.4	20.0	0.0	25.0	9.8	11.8	20.0	11.4

TABLE II (Continued)

Educate public about mental health and the roles of specialists	0.0	8.0	8.3	13.4	14.0	19.4	0.0	0.0	22.2	17.9	5.9	0.0	10.5
Require higher standards for workers in respondent's profession	0.0	6.0	11.8	2.4	2.3	9.7	0.0	16.7	8.3	11.3	0.0	20.0	10.1
Institute "progressive" laws, educate legislators, etc.	0.0	12.0	7.2	14.6	4.7	9.7	20.0	16.7	8.3	14.6	5.9	0.0	8.9
Make more jobs available	0.0	4.0	8.8	8.5	2.3	6.5	20.0	0.0	22.2	5.7	5.9	0.0	8.1
Improve social, cultural, recreational facilities	50.0	0.0	6.0	2.4	3.5	16.1	0.0	5.6	16.7	6.5	5.9	0.0	7.3
Improve attitudes of administrators	0.0	20.0	6.5	6.1	0.0	6.5	0.0	0.0	2.8	3.3	16.6	20.0	6.4
Establish or improve professional organization in respondent's field	0.0	8.0	5.7	11.0	14.0	0.0	0.0	0.0	5.6	4.9	0.0	0.0	6.0
Reduce political control	0.0	0.0	1.7	6.1	2.3	0.0	0.0	5.6	0.0	0.0	0.0	0.0	1.7
Respondent says his state is highly attractive as it is	0.0	0.0	2.9	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.8

*Statistical Supplement to the Report of Mental Health Training and Research in the Western Region, June 1956.

that state personnel policies should be improved in the areas of retirement and standards of the merit system. (The number of respondents answering this item coincided with the responses on Table II in which only 2.8 per cent of the specialists felt that the personnel policies were adequate.)

The two items that were not answered by a single respondent were those concered with (1) the improvement of the professional organization, and (2) the reduction of political control. (According to Table II, there were no respondents who felt that there was an active professional group in Montana and only 2.8 per cent of the respondents felt that there was a lack of political interference). It would appear that even though there is an awareness of the lack in the areas of the profession and control of the profession, there is no particular interest about changing the situation.

It has been shown that the survey pointed out some of the overall strengths and weaknesses of western state programs and also attempted to analyze the community services that are available in each state. The study attempted to show the extent of the present facilities and to suggest ways in which services can be expanded and improved to meet present needs.

In order to analyze the state programs, the survey committees attempted to classify the state programs in three areas:

1. Prophylactic, the control of diseases which follow a clear-cut sequence from a known, eradicable cause to a specific effect.
2. Remedial preventive programs, offering diagnosis and treatment for persons with symptoms of emotional maladjustment or mental illness. In planning the survey, the committees intentionally omitted the assessment of treatment programs.
3. Educational preventive programs designed to help people maintain good mental health through positive educational experiences such as parent education, etc.[5]

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[5] Ibid., p. 31.

The survey included questionnaires from all persons and agencies who work with people who have emotional problems. Since the respondents cover such a broad area, it is probable that the answers submitted are ambiguous and impractical for the purpose of this paper which is to analyze present facilities in Montana. At least, the questionnaires point out some of the areas of confusion in dealing with mental health problems which hamper the efficiency of the program.

Sixty per cent of the directors of agencies dealing with emotional problems who answered the questionnaire, reported that the services provided by the mental health specialists are inadequate. The largest response by agency directors in Montana indicated that they feel there should be more specialists in the state. The survey shows that this possibility is not feasible because of the lack of funds and the shortage of training centers.

In addition to the reports from the agencies, the school administrators as a whole, felt that they were unable to hire the necessary specialists in the school systems. The reason for the shortage in the area of education are inadequate funds, insufficient trained personnel, and the lack of public support.

Since agency directors have been unable to hire specialists in the field of mental health, the reports of the psychiatrists are valuable in pointing out obstacles that might cause a shortage of qualified doctors. In Montana the services of a psychiatrist are especially vital to the program since the psychiatrists are the directors of the individual clinics. A clinic cannot be organized unless the services of a psychiatrist are available.

Table III shows the percentages of psychiatrists in private practice who report various obstacles to effective practice. (There are no tables showing the viewpoints of the state psychiatrists. In Montana it is difficult to classify status of psychiatrists in the clinic program since some of those in private practice are hired by the state on a part-time basis.)

Table III shows that there were only two items answered by the Montana respondents and they were answered by one hundred per cent of the specialists. Since there were only four private psychiatrists in Montana at the time of the survey, the group is probably too small to be considered representative of the profession.

The two items that were checked as obstacles that interfere with the services of the psychiatrist are "inadequate treatment" and "inadequate number of mental health specialists." (Since none of the other items was checked which might indicate partial solutions to the problem, it is difficult to determine what the answers might be.) Montana was the only state that listed less than three obstacles to effective service.

Table IV shows the responses of the psychiatrists in private practice regarding the availability of mental health specialists. The only item which was named by the respondents was that "There are too few mental health specialists in the state." Since there was a lack of responses in other areas, it is difficult to account for the shortage of personnel if everything else in the program seems satisfactory. Any items that might point out weaknesses in the program or the state were not checked. Wyoming is the only other state whose respondents marked only one item which was the same item that was marked by the Montana respondents. It is difficult

TABLE III*

PERCENTAGES OF PSYCHIATRISTS IN PRIVATE PRACTICE REPORTING VARIOUS OBSTACLES THAT NEED TO BE OVERCOME FOR THEM TO SERVE MOST EFFECTIVELY IN THEIR PSYCHIATRIC PRACTICE, BY STATE
(Since a single respondent could give more than one answer, the percentages do not add to 100.)

	State										
Obstacle	Ariz.	Calif.	Colo.	Ida.	Mont.	Nev.	N. Mex.	Ore.	Utah	Wash.	TOTALS
Lack of understanding or roles of psychiatric professionals	80.0	60.0	41.7	0.0	0.0	100.0	50.0	18.2	80.0	52.9	56.0
Inadequate treatment, service, diagnostic	40.0	38.4	58.3	100.0	100.0	100.0	0.0	45.5	20.0	35.3	39.6
Inadequate numbers of mental health specialists	60.0	27.2	50.0	100.0	100.0	0.0	50.0	45.5	20.0	17.6	30.8
Lack of coordination of mental health service	20.0	14.4	8.3	100.0	0.0	100.0	25.0	27.3	0.0	11.8	15.4
High cost of psychiatric care; health insurance inadequate	0.0	8.8	0.0	0.0	0.0	0.0	0.0	9.1	0.0	5.9	7.1
Personal lacks in the respondent himself	0.0	5.6	8.3	0.0	0.0	0.0	0.0	18.2	0.0	0.0	5.5
Inadequate laws concerning mental illness	0.0	4.0	0.0	0.0	0.0	0.0	0.0	9.1	0.0	5.8	3.8
Lack of study and research time or facilities	0.0	4.8	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	3.3
Respondent says he encounters no obstacles	0.0	4.8	0.0	0.0	0.0	0.0	25.0	18.2	0.0	11.8	6.0

*Statistical Supplement to the Report of Mental Health Training and Research in the Western Region, June 1956.

TABLE IV*

PERCENTAGES OF PSYCHIATRISTS IN PRIVATE PRACTICE GIVING VARIOUS RESPONSES TO THE ITEM, "PLEASE COMMENT ON THE AVAILABILITY OF MENTAL HEALTH SPECIALISTS, INCLUDING SUCH THINGS AS THE FACTORS RESPONSIBLE FOR LACK OR ADEQUACY OF MENTAL HEALTH SPECIALISTS," BY STATE
(Since a single respondent could make several comments, the percentages do not add to 100.)

	State											
Comment	Ariz.	Calif.	Colo.	Ida.	Mont.	Nev.	N.Mex.	Ore.	Utah	Wash.	Wyo.	TOTALS
There are too few mental health specialists (of one type or another)	20.0	14.6	75.0	0.0	100.0	50.0	33.3	66.7	33.3	30.0	100.0	25.4
There are too many specialists; field is overcrowded	0.0	30.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	60.0	0.0	25.4
Salaries for professionals are too low	40.0	15.9	50.0	0.0	0.0	0.0	0.0	16.7	33.3	0.0	0.0	17.2
Lack of training facilities limits number of specialists available	20.0	10.0	12.5	0.0	0.0	0.0	0.0	16.7	0.0	0.0	0.0	9.0
Poor training facilities turn our incompetent professionals	0.0	8.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	10.0	0.0	6.6
There are insufficient incentives to enter the field	20.0	7.3	12.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	6.6
Training period is too long or training is too difficult	0.0	7.3	12.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	5.7

*Statistical Supplement to the Report of Mental Health Training and Research in the Western Region, June 1956.

to know if the lack of responses represents satisfaction with the policies and standards, or whether there is a lack of interest in exploring the weaknesses. Perhaps one reason for a lack of suggested changes is that there is no coordinating agency in Montana to help correlate policies among agencies and institutions. Also the absence of a strong professional organization would account for a lack of interest in standards.

Research. It has been shown that well-staffed community clinics would be a partial answer to the need for psychiatric service; however, from a long-range point of view, research is probably the ultimate answer to preventing mental illness and it is one of the major areas to be explored as outlined in the Mental Health Act. Because of the intangible results and the long-term programs, it is the area that is the most neglected in the field of mental health.

In the western states the returns from 1,420 mental health specialists show that they are engaged in 883 research projects related to the problem of mental illness. The specialists also report that there are 1,383 additional research projects that they would like to undertake.[6] Thus, there is interest in carrying out nearly three times as much research as is currently in progress.

Since there is a desire among the specialists for additional research, Table V points out the obstacles that prevent research. About one-third of the total number of answers indicate that the respondents feel their jobs are time-consuming and there is not ample opportunity for research projects.

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[6] Ibid., pp. 29-30.

TABLE V*

PERCENTAGES OF MENTAL HEALTH SPECIALISTS REPORTING VARIOUS BARRIERS TO RESEARCH THAT EXIST IN THEIR INSTITUTIONS, BY STATE

(Since a single respondent could mention several barriers, the percentages do not add to 100.)

	State												
Barrier to research	Alas.	Ariz.	Calif.	Colo.	Ida.	Mont.	Nev.	N.Mex.	Ore.	Utah	Wash.	Wyo.	TOTALS
Too little time allowed; service time too demanding	100.0	60.9	62.9	54.2	57.1	40.7	75.0	53.8	45.5	57.5	40.7	60.0	59.7
Lack of funds	50.0	67.4	40.8	48.2	57.1	63.0	75.0	38.5	48.5	35.8	81.5	80.0	44.7
Professionals inadequately trained; lack of research oriented people	50.0	39.1	42.0	26.5	28.6	48.1	50.0	23.1	27.3	21.7	25.9	40.0	37.3
Professional "climate" unfavorable to research	50.0	26.1	28.4	20.5	42.9	18.5	50.0	23.1	24.2	24.5	14.8	0.0	26.7
Lack of space, equipment or other facilities	50.0	28.3	10.7	15.7	28.6	25.9	0.0	23.1	18.2	12.3	14.8	20.0	13.4
Interdisciplinary communication is poor	50.0	2.2	8.3	2.4	4.8	11.1	0.0	7.7	3.0	13.2	3.7	0.0	7.8
No barriers exist; research strongly encouraged	0.0	0.0	1.2	4.8	0.0	0.0	0.0	0.0	3.0	3.8	3.7	0.0	1.8
Number answering item	2	46	647	83	21	27	4	13	33	106	27	5	1014

TABLE V (Continued)

There is lack of public of professional "acceptance"	0.0	4.9	12.5	0.0	0.0	0.0	0.0	16.7	33.3	0.0	0.0	5.7
Stigma of mental illness should be removed; prevents people from entering field	0.0	3.7	12.5	0.0	0.0	50.0	0.0	0.0	0.0	0.0	0.0	4.1
Increasing awareness of needs makes more jobs available than can be filled	20.0	2.4	0.0	0.0	0.0	0.0	33.3	0.0	0.0	0.0	0.0	3.3
Professionals now available are poorly utilized	0.0	2.4	0.0	100.0	0.0	0.0	33.3	0.0	0.0	0.0	0.0	3.3
Students should be encouraged to enter the mental health field	0.0	4.9	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	3.3
Specialists often are ignorant of community organization or needs	0.0	3.7	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2.5
There is lack of interdisciplinary or interinstitutional cooperation	0.0	3.7	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2.5
Shortage is "natural" due to newness of the field	0.0	2.4	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.6

*Statistical Supplement to the Report of Mental Health Training and Research in the Western Region, June 1956.

There were 27 specialists that answered the items in Table V who were from Montana. Of this number of respondents, 48.1 per cent felt that the professionals were inadequately trained and insufficiently motivated toward research. The response to this item might be indicative of the reasons for a lack of interest in improving the professional organization even though the responses showed that professional standards are not high in the Montana program.

The greatest barrier to research in Montana is the lack of funds as indicated by 63.0 per cent of the respondents who answered that item. The lack of sufficient money to conduct research seemed typical of the situation of most states since in all of the states represented at least thirty-eight per cent of the respondents named that particular item.

In Montana 40.7 per cent of the specialists felt that their work was too time-consuming, allowing little time for research. It is probable that both a change of policies and an increased emphasis upon research in the state program might be partial solutions to the problem.

The Interstate Commission for Higher Education has made suggestions for improving the "professional climate" to encourage research. The following suggestions were made:

1. Active encouragement of research by the policy makers

2. More frequent statewide and regional meetings for discussion of research activities

3. Liberalization of travel allowances.[7]

In order to carry out the above-mentioned policies, there must be

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[7] Ibid., pp. 48-52.

research-oriented people in the program, who have a strong interest and pride in their profession.

Since nearly one-fourth of the respondents listed lack of funds as the barrier to research, it might be of value to show a breakdown of the financial support for the current 883 projects.

A breakdown of the statistics shows the following distribution of funds:

State sources - - - - - - -	291 projects	33⅓ per cent
Federal sources- - - - - - -	176 projects	20 per cent
Personal sources - - - - -	150 projects	17 per cent
University sources - - - -	133 projects	15 per cent
All other sources - - - -	133 projects	15 per cent[8]

Although the compiled list of sources does not show the total amount of funds involved, the amount is inadequate to meet mental health needs in the areas of treatment and education. There is only one state in the western state region in which funds are specifically provided for research through the state department.

According to suggestions by respondents in the survey, the western region offers possibilities for a "research laboratory" in which funds are specifically provided for research through the state department.

According to suggestions by respondents in the survey, the western region offers possibilities for a "research laboratory" in which interested persons can work together on projects where the facilities are available. In order to make such a plan feasible, the administrators would have to encourage time and money being spent for research as part of the mental health program.

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[8] Ibid., pp. 51-54.

Training. In addition to the obstacles encountered in the areas of research and community services, the survey attempted to point out the training opportunities that are available in the western states. The results of the survey indicated that one reason for a shortage of personnel is the long training period involved in educating specialists. Also the competition for existing personnel has resulted in the Veterans' Hospitals being somewhat better staffed than state hospitals or clinics.

In Montana there are no training facilities for psychiatrists, psychologists at the Ph. D. level, psychiatric social workers and psychiatric nurses. The Montana mental health personnel and the Montana Society for Mental Health, have discussed methods of training people in related professions to work with people who have mild emotional problems. They feel that such a plan would help to solve the problem of the shortage of trained people in the field of mental health.

Table VI shows the changes that have been suggested by private psychiatrists to better train physicians to work with persons with emotional problems. Although the items concerned courses in medical school and in the line of experience, only one item was marked. One hundred per cent of the respondents felt that physicians should be trained in the "whole man approach" which would enable them to give consideration to the implication of the psychiatric problems.

Montana was the only state on the survey for which only one item was marked. Since the psychiatrists offered no other suggestions for helping the physician become more effective, the value of the response is questionable. Since there are only four private psychiatrists in the state, and they have different problems regarding the patient load than

TABLE VI*

PERCENTAGES OF PSYCHIATRISTS IN PRIVATE PRACTICE SUGGESTING VARIOUS CHANGES THAT MIGHT BE MADE IN THE TRAINING OF THE NON-PSYCHIATRIC PHYSICIAN TO PREPARE HIM BETTER TO HANDLE THE MENTAL HEALTH PROBLEMS HE ENCOUNTERS IN HIS PRACTICE, BY STATE

(Since a single respondent could make several suggestions, the percentages do not add to 100.)

	State										
Suggested change	Ariz.	Calif.	Colo.	Ida.	Mont.	Nev.	N.Mex.	Ore.	Utah	Wash.	Wyo.	TOTALS
Changes in medical schools:												
More courses in psychiatry	40.0	19.3	18.2	0.0	0.0	0.0	50.0	16.7	0.0	11.8	0.0	18.2
Improved lectures in psychiatry and related fields	0.0	11.7	0.0	0.0	0.0	0.0	25.0	8.3	0.0	11.8	0.0	10.3
Earlier introduction of psychiatry in curricula	0.0	9.0	18.2	0.0	0.0	50.0	0.0	16.7	0.0	5.9	0.0	9.4
Increase relative importance of psychiatry in curricula	0.0	9.0	0.0	0.0	0.0	0.0	0.0	8.3	0.0	0.0	0.0	6.9
Reduced Freudian emphasis; more work in "fundamentals"	0.0	2.1	0.0	100.0	0.0	0.0	25.0	0.0	25.0	5.9	0.0	3.4
Changes in post-graduate work:												
Psychiatric seminars and supervised training during internship and residency	20.0	17.9	36.4	0.0	0.0	0.0	0.0	8.3	0.0	11.8	0.0	16.7
Post-graduate courses for general practitioners and hospital staffs	20.0	11.7	27.3	0.0	0.0	0.0	0.0	0.0	25.0	5.9	0.0	11.3

TABLE VI (Continued)

More experience with non-psychotic psychiatric patients	0.0	9.9	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	6.4
Longer internships in psychiatric wards	0.0	4.1	18.2	0.0	0.0	0.0	25.0	0.0	0.0	0.0	0.0	4.4
General changes:												
Better training for early recognition of symptoms	0.0	10.3	18.2	100.0	0.0	50.0	0.0	8.3	25.0	0.0	100.0	10.8
Improved correlation among educational, experimental, and practical facilities	0.0	0.7	9.1	0.0	0.0	0.0	0.0	0.0	0.0	5.9	0.0	1.5
Changes in attitudes & policies:												
Train physicians in the "whole man" approach, e.g., give training in psychosomatic medicine	20.0	38.6	36.4	100.0	100.0	50.0	25.0	50.0	25.0	41.2	100.0	39.4
Improve integration of different medical disciplines	0.0	0.0	0.0	0.0	0.0	0.0	0.0	25.0	25.0	11.8	0.0	3.0
Give the psychiatric field more and better publicity	20.0	0.7	0.0	0.0	0.0	0.0	25.0	0.0	25.0	0.0	0.0	2.0
Advise caution on the dangers of amateur psychotherapy	0.0	2.1	9.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2.0
Bring in psychiatric consultant on all major surgery	20.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	25.0	0.0	0.0	1.0

*Statistical Supplement to the Report of Mental Health Training and Research in the Western Region, June 1956.

the state psychiatrists, they are not a representative group.

Perhaps one value of the survey would be in pointing out avenues which should be explored in the area of mental health. Since the study is inconclusive because of the ambiguity of terms and the lack of responses, there is a need for further studies. Intensive studies are necessary to determine ways of meeting needs for funds and training in order to provde more effective treatment and prevention.

CHAPTER IV

THE ORGANIZATION OF CLINIC PROGRAMS

This study has shown how the punitive attitude of Colonial America toward mental illness has gradually changed to a general attitude emphasizing treatment of the sick based upon scientific findings and research. The Mental Health Movement led by Clifford Beers gave impetus to public awareness of the scope of the problem and the need for a cooperative state and federal program. The magnitude of the problem of mental illness ultimately led to the enactment of the Mental Health Act which emphasized the three-way attack to the problem. The Act made provision for exploring the three areas of research, training, and community services.

Since this study is primarily concerned with the mental health program in Montana, this chapter will deal with general findings and principles regarding clinic programs in other states. The results of research and experimentation will be used as a basis for understanding and evaluating the present program in Montana. An attempt will be made to determine which principles and procedures might be applicable and practical to help solve the problems of insufficient personnel to meet the demand for services.

Clinic Programs. The development of psychiatric clinics came into existence in this country in the beginning of the twentieth century and were the result of the Mental Hygiene movement and the development of the

Child Guidance movement.

The earliest clinics developed from the thinking of Dr. Adolf Myer and others who stressed the importance of considering the patient as a whole and of trying to understand him as a person. The first clinics for mental patients which emphasized treatment in the early states of illness were established in 1895 at the Pennsylvania General Hospital by Dr. John Chapin and at the Boston Dispensary in 1898 by Dr. Walter Channing.[1]

Althoug the first clinic came into existence in the nineteenth century, the use of the "team" approach of psychiatrist, psychologist, and psychiatric social worker did not develop until 1910. The Boston Psychopathic Hospital (1912) and the Henry Phipps Psychiatric Clinic of Johns Hopkins University (1913) are generally credited with being the first clinics to make use of social work.[2] Some of the workable principles in clinic functioning were the result of the accomplishments of the team approach in the study and treatment of patients.

Organization. To understand the function of a clinic, a definition will clarify the reason for its existence.

> The psychiatric clinic is an organization established to treat the mental and emotional ills of individual patients and on a broader scale to prevent such ills in the community.[2]

It should be remembered that clinics are not a cure-all but represent just one grouping of scientific knowledge for the treatment of individual and social ills. They are successful only in the measure in which they can be coordinated with other community resources and techniques.

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[1] A. Z., Barhash and others, Community Psychiatric Clinics (New York: National Association of Mental Health, 1952), pp. 8-9.

[2] Ibid., p. 10.

The work of a clinic although in main respects is similar to the treatment methods of the private psychiatrist, differs from his in two respects:

1. In a clinic treatment is accomplished through the coordinated effort of a clinic team rather than through the individual effort of one therapist.
2. The work of a clinic is less limited than helping individual patients and carries responsibility for advancing the mental health of the total community.[3]

Further, the clinic should be active in constructive mental health planning through participation in community activities.

The first step toward organizing a clinic should be for the organizing group to study the community needs and resources. There should also be a decision regarding what the primary function of the clinic should be, and this decision should be based upon the type of problem that a clinic should attempt to solve.

The organizing group often should be made up of people who are employed in agencies which recognize the need for mental health facilities. In recent years, an increasing number of state hospitals have accepted as their responsibility leadership in the community in program establishment.

Regardless of the nature of the initiating group, one of its functions should be to contact all of the agencies that work with people. This step is necessary because in order to insure sound organization, it is necessary to have integration with the community agencies.

Some of the community agencies that should be canvassed in program planning are:

1. Family and children's agencies

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[3] Ibid., p. 10.

2. Welfare department, particularly those involved in the state programs of old age assistance and aid to dependent children.
3. Community chest organization and councils of social agencies
4. Courts and probation departments, particularly juvenile courts institutions of higher learning where they are in a position to play a community role.
5. Mental hospitals, both state and private: general hospitals and Veterans Administration hospitals
6. Departments of health, departments of mental hygiene, local, county, or state
7. Local or regional offices of the Public Health Service
8. County medical societies, and individual medical practitioners who have a special interest or a special competence in the field of mental health
9. Service organizations, fraternal organizations and individuals who might give organizational or financial assistance in the creation of the desired effort
10. Labor organizations and other groups which are interested in service to their members and to the community at large
11. Church groups, including individual pastors, and sectarian social services set up by churches
12. Local foundations
13. Individual civic leaders who are able to contribute to the effort because of their special interest.[4]

The organizing group should work with representatives of the types of agencies mentioned above in order to work out effective goals and plans for treatment.

Surveys. It is usually advantageous for a community that is in the process of organizing a program to make an extensive survey of the community needs and resources. The survey should indicate community readiness for the program, possibilities for initial and continued support of the program, types of service for which there is most demand. Since there are few people qualified to conduct a worthwhile survey, it would be advisable to contact the Division of Community Clinics of the National Association for Mental Health. Their staff will help or advise where resources are available for qualified people to conduct a survey.

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[4] Ibid., pp. 15-16.

After the organizing group has evaluated the community needs and resources, the goals should be set up in broad, general terms as follows:

1. Aim and purposes—What are we working for?
2. Scope—In what area do we work?
3. Potential program—What might we do?
4. Program—What do we intend to do?
5. Activities—What are we doing?
6. Reports—What did we do?[5]

If the groups can satisfactorily work out answers to the above questions, it should have a clear general idea of some of the aspects of the program. In working out some of the aspects of the program, it is necessary that the group work slowly, meet regularly, and record their findings.

Policies. A study of typical clinics would indicate that their programs would include certain basic policies which are as follows:

1. Provide more treatment for more patients in the community
2. Community clinics will save many patients from state hospitals
3. More psychiatrists, clinical psychologists, social workers, and psychiatric nurses are the answer to the mental health problem
4. The basis of prevention is correction of faulty child-rearing practices and the treatment of emotional disorders of childhood
5. Knowledge of the psychological development of the child by professionals and laity is the keystone of mental health
6. Ministers, school teachers, recreational workers, and mental hygiene societies can stave off tendenceies to mental disorders
7. Mental Health is a state for which individuals can be educated by disseminating knowledge about emotional processes through pamphlets
8. The problem of mental and emotional disorder should be attacked broadside on a mass scale reaching as many of the population as possible irrespective of the current state of mental health of any individual or family
9. Unconscious psychological determinants are the major explanation of maladaptive reactions

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[5] George Stevenson, "Present Trends and Future Outlook," Psychiatry in the Community, (Lancaster: The Science Press, 1939), pp. 45-49.

10. An understanding of casuality in human behavior is more effective in improving mental health than is emphasis on surface effects.[6]

This list illustrates that clinics have responsibilities in both areas of treatment and education.

Staff Procurement. One of the most difficult tasks in organizing a clinic is to obtain a well-qualified staff; every community must realize that a worthwhile program is impossible without trained people. The staff members should be qualified for their positions by training, experience and personality. The three members of a psychiatric team are usually the minimum number of staff members for effective service to the community. The first person to be selected should be the director of the clinic, and he should then become active in selecting additional people. This should be done in cooperation with the board or the organizing group for the program.

The psychiatrist should be an applicant for admission to the American Board of Psychiatry and qualified by training and experience to be admitted to the Board examination. He should also be qualified to treat the emotional problems which make up the bulk of the clinic patients. It is possible in planning a clinic program to hire a psychiatrist who is well-qualified in working with psychotic patients in a hospital set-up but who would be unable to be successful in a responsible clinic program.

The training of a psychologist is difficult to describe because of the lack of standardization policies. The professional group that sets

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[6]Public Health Service Publication, Evaluation in Mental Health No. 413, (Washington: United States Department of Health).

standards is the Committee on Training in Clinical Psychology of the American Psychological Association. The committee emphasizes a Ph. D. as a necessary requirement for clinical work and so does the American Orthopsychiatric Association. Because of the shortage of training facilities throughout the country, substitutions are made for training. It is important that a clinical psychologist be hired or otherwise a well-trained psychologist might be hired who is not equipped to work in a psychiatric clinic.

A psychiatric social worker is qualified for clinic work by a two-year graduate course from an accredited school of social work. The American Association of Psychiatric Social Workers sets the standards for this group. There is often difficulty in evaluating the experience of the older workers and the National Association for Mental Health will usually give assistance in selecting staff members.

Clinic Financing. After a community program has been organized, consideration should be given to the financial backing. The general cost of clinic operation has been explored and $37,000 yearly is the estimated cost of operation. This would include a psychiatrist, two social workers and one psychologist. This amount would also include the necessary rental and overhead expenses.

The sample budget is ample to cover most expensive items although some items may fluctuate in cost.

The initial equipment for the clinic is not included in the above operation budget. Costs would probably run from $2,000 to $3,000 including such items as office equipment, dictaphone, typewriters, toys for play therapy and psychological materials.

TABLE VII

SAMPLE BUDGET SHOWS THE APPROXIMATE COST OF CLINIC OPERATION WHICH SHOULD COVER MOST EXPENSIVE ITEMS

Salaries*	
Psychiatrist-Director	$12,000
Clinical Psychologist	5,000
Chief Psychiatric Social Worker	5,000
Psychiatric Social Worker	3,600
Office Manager and Secretary	3,000
Stenographer	2,600
	$31,200
Rent**	2,000
Heat, Light, Water	300
Telephone and Telegraph	400
Stationery and Office Supplies	300
Postage	100
Insurance	250
Social Security	300
Retirement***	1,000
Conference Travel	300
Repairs and Replacement to Equipment	150
New Equipment	100
Educational Supplies and Toys	150
Dues	100
Publications	75
Miscellaneous	200
Total	$36,925

*Salaries are the most changeable of these items and naturally have increased considerably in the past years. It will be important to check this item against national figures to get the current picture.

**Items such as rent, heat, telephone, insurance, etc. should be checked locally especially comparing with the expenses of other social agencies as a guide.

***Retirement depends on individual rates. Clinics using this item usually budget $1,000.[7]

[7] A. Z. Barhash, and others, Community Psychiatric Clinic (New York: National Association for Mental Health, 1952), Appendix I, p. 99.

In order to insure a sound start for the operation of a clinic, there should be sufficient money to operate for a minimum of three years. The money should be on hand or should have been pledged by a reliable source. The Division on Community Clinics indicates that it is too risky to start a clinic without the financial assurance of operation for three years since it is difficult for a clinic to prove its worth in less than that amount of time.

Local groups should be ultimately responsible for the permanent financing of the clinic. Although the Community Services Fund of the National Mental Health Act provides a source of support, the funds are not sufficient for permanent support of a program. The funds are to be used primarily for starting new programs or expanding old ones. The report of the House Committee on Appropriations of the 80th Congress stated:

> The committee is very much interested in the programs and objectives of the Public Health Service and desire to financially implement these programs with every dollar to be expended. However, it is to be expected that the state and local communities will eventually shoulder the cost.[8]

Therefore, the community groups should think in terms of long term planning for the future maintainance of its program.

After the initial planning regarding funds, it is necessary to determine the financial responsibility for operation. Clinical experience has established the criterion that payment for mental health services should be made by the individuals receiving the benefits of service.[9] If a patient is unable to pay for treatment, the group most closely identified

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[8] Ibid., pp. 35-39.

[9] Leonard A. Scheela, Surgeon General, General Principles of the Federal Program For Mental Hygiene (Washington: United States Public Health Service, 1949), pp. 34-35.

with him would be responsible. Therefore, the payments would be made by the patient's family, church organization, welfare or fraternal organization, etc. It is important in all situations involving money that the matter be worked out carefully with the patient.

The policy of "fee charging" where the patient assumes the responsibility has worked successfully with many clinics. This principle is considered to be of therapeutic value to the patient in addition to the financial value.

TABLE VIII

SAMPLE FEE SCHEDULE BASED UPON THE YEARLY INCOME OF THE PATIENTS

Sample Fee Schedule*

Yearly Income	Fee Per Visit According to number of dependent children					
	1	2	3	4	5	6
$ 3,000- 4,000	$ 3.00	$ 2.00	$ -	$ -	$ -	$ -
4,000- 5,000	4.00	4.00	3.50	3.50	3.00	3.00
5,000- 6,000	8.00	8.00	5.00	5.00	5.00	5.00
6,000- 7,000	12.00	12.00	10.00	10.00	9.00	9.00
7,000- 8,000	12.00	12.00	10.00	10.00	10.00	10.00
8,000- 9,000	15.00	12.00	10.00	10.00	10.00	10.00
9,000-10,000	15.00	15.00	12.00	12.00	12.00	12.00
10,000-and up	20.00	20.00	15.00	15.00	15.00	15.00

*Fees are invariably waived for patients with low incomes and where payment would constitute a real hardship. They may be adjusted in accordance with unusual financial obligations as well as for the number of dependents. A compilation of sample fee schedules currently in use in psychiatric clinics is available from the National Association for Mental Health.[9]

[9]A. Z. Barhash, op. cit., p. 34.

The sample schedule that is illustrated is practical because it permits those with the largest income to carry the greatest financial responsibility. The schedule should be sufficiently flexible to be waived for people who are under a heavy financial strain. In individual situations, the amount of fees would probably be decided by the entire clinic staff rather than by the social worker.

Although a small part of the operating cost can be borne by individual patients and groups, the greatest share of the responsibility must come from other areas. The state governments often assume the cost of clinic operation (in addition to the money provided through federal sources under the National Health Act.)

The states have recognized their responsibilities since the problem of mental health has reached such magnitude as to be considered a public health problem. In many states a department of mental health has been established to carry out the administrative details and the program is tax-supported through legislative action.

Besides federal and state support of clinic programs, in some communities local organizations carry a share of the financial responsibility. Some agencies that have been active are the Community Chests, Junior Leagues, Kiwanis Clubs, and veterans groups. Some schools and industries have also given financial assistance for service rendered. Although local sources vary among the communities, the organizing group should be familiar with the possibilities of using local financial help.

Intake Policy. After the necessary steps have been taken to organize the planning committee which sets up a program, and the financial arrangements have been worked out, the first consideration should be with

the intake policy. Not only does this prcedure determine the success of the clinic, but it is important in affecting community relationships.

Some clinics have been unable to operate efficiently because they felt an obligation to accept for service anyone who contacted the clinic. This policy has resulted in waiting lists with over-worked personnel and dissatisfied patients. Recognizing this weakness in program planning, the Mental Health Study Center initiated an experiment to study "intake policy." The Prince George's County (Maryland) Mental Health Clinic offered a limited program of service to residents of the county. The Center changed its intake policy in two basic areas:

1. All individuals requesting clinic service would have to be referred by some other professional source, and

2. All referring sources were to contact the Center prior to actual referral to discuss with a staff member the particular situation.[10] By this policy, the Center made more adequate use of psychiatric time and personnel and also had fewer intake failures and less frequent patient terminations. Because the Center had some control over the number and type of patients who were treated, resulting in a more efficient use of clinic time, the personnel were better prepared to treat people on an emergency basis.

In order to evaluate the policy, a follow-up study was made for one year (July, 1952-1953)[11] with the results shown in Table IX.

The one hundred and eighty people who contacted the clinic were advised to have a professional person make an appointment for them.

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[10] Miller Rooney, "A Mental Health Clinic Intake Policy Project," Mental Hygiene, Volume 39, No. 3, July 1955, p. 393.

[11] Ibid., p. 396.

TABLE IX

SURVEY SHOWING DISPOSITION OF REFERRALS TO A CLINIC

Total Number Referred	180 patients
Number about whom the clinic was consulted	88 patients
Number accepted for service	61 patients
Number of those who followed through	50 patients
Number not accepted	27 patients
Number to whom questionnaire was sent	92 patients
Number of those who replied to questions	66 patients

Approximately fifty per cent of the original number were later called about by a professional person in the community; approximately seventy-two per cent of the balance answered the questionnaire sent to them. The remaining group from whom nothing was heard comprise fourteen per cent of the original callers. During the same year, the total clinic intake volume from all sources was 125 families. Thus, forty per cent of this group were originally "self-referrals."

This study showed that when the patients had the responsibility of taking the initiative to "do something about their problems," the ones who were the most concerned were probably referred by a professional person. Others probably worked out their own solutions and received help from other sources.

Although the experimentation with the Intake Policy of the Prince George's County Mental Health Clinic may not be conclusive enough to be a

basis for the forming of policies, it is possible that some of the general principles would be practical in most communities. At least the policy might deserve consideration when there is a "waiting list" for treatment such as exist in some Montana clinics.

Traveling Community-Mental Health Clinics. In some states traveling clinics have been helpful in offering services to communities who might not otherwise be able to obtain clinic services. One of the primary purposes of a traveling clinic is to train the personnel of community agencies in becoming more effective in their duties with their clients.

Although the same team is included in the traveling clinics as in the stationary ones there is one principal difference: the traveling clinic is a cooperative enterprise between its members and some community agency and generally the psychiatrist and psychologist are the traveling members of the team and the social worker is furnished by the community. The amount of traveling, number of patients seen, etc., depends upon the community needs and facilities and the number of personnel on the traveling team.

The duties of a traveling team are often broader in scope than the non-traveling ones. Their responsibilities are three-fold:

1. To give services to the patients which is primarily concerned with diagnosis and treatment.
2. Services to the agency which center around consultation and in-service training.
3. Service to the community is concerned with helping to stimulate an interest in mental health problems and to develop community resources along the mental health lines.

The members of a traveling team should be aware of responsibilities in seven areas which are as follows:

1. Therapy

2. Evaluation and Psychological Testing
3. Consultation
4. In-Service Training
5. Clinic-Community Relationships
6. Community Organizations
7. Aid for Community Planning[11]

In some instances consideration will be given to one responsibility more than another one depending upon the type of community encountered and also upon the number and training of the clinic personnel; however, the members should be aware of responsibilities in all areas. The main emphasis of traveling clinics is to develop community potentialities rather than to given intensive treatment to individual patients.

In this chapter workable policies and techniques have been discussed that have been valuable in clinic operation. In order to evaluate the program in Montana, it is important to understand effective policies that might be applicable to Montana. It should be remembered that clinics can be effective only to the degree that they are properly staffed, can coordinate with other resources already available, and are called upon to perform tasks suited to their specialized skills. Since the situation in Montana shows an insufficient number of personnel to meet the demand for services, methods of eliminating patient load and still give good service should be analyzed.

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[11] Huessy Hopple, "Traveling Community-Mental Health Clinics," Mental Hygiene, November, 1954.

CHAPTER V

THE MENTAL HYGIENE PROGRAM OF MONTANA

The setting in which this study was made was the Mental Hygiene program of Montana. For a better understanding of the background of the problem a description of the organization, its services and standards are briefly reviewed. Information will be used regarding the clinic in Butte when the policies are typical of other Montana clinics since the writer is most familiar with the functions of that clinic.

There are four mental hygiene clinics in Montana, the third largest state in the Union with a population of 660,000 people, and covers an area of 146,000 square miles. Because of the sparse population and wide area, "space" and "distance" are important factors in program planning in Montana.

Other mental health facilities are the state hospital located at Warm Springs with an average patient load of nineteen hundred; the state institutions concerned with mental health problems are: (1) Montana State Industrial School, Miles City; (2) Montana State Orphans Home, Twin Bridges; (3) Montana State School for the Deaf and Blind, Great Falls; (4) Montana State Training School, Boulder; (5) Montana State Tuberculosis Sanitarium, Galen; (6) Montana State Vocational School for Girls, Helena; (7) Montana State Prison, Deer Lodge; and (8) Home for the Senile Aged, Lewistown.

The institutions of higher learning which offer possibilities for

future training in the area of mental health are the six units of the University. These schools are (1) Montana State University, Missoula; (2) Montana State College, Bozeman; (3) Western Montana College of Education, Dillon; (4) Montana School of Mines, Butte; (5) Eastern Montana College of Education, Billings; and (6) Northern Montana College, Havre.

ORGANIZATION

Five mental hygiene clinics were organized under the State Department of Mental Hygiene which was created in 1947. (One clinic become inactive after two years of operation because of an insufficient demand for its services). The National Institute of Mental Health (one of eight institutes under the Public Health Service) provided leadership and financial assistance in the program planning. It included help in the preparation of legislation, advice in the fields of psychiatry, psychology, and psychiatric social work; aid with public information program; assistance in establishing relationships with other interested agencies such as public welfare agencies; and overall administration of programs and planning.

The Montana program is financed by legislative appropriations primarily although the Public Health Service provides twenty per cent of the total sum. Disbursements for the fiscal years of 1955 and 1956 are as follows:

	STATE	FEDERAL
1955-1956	$68,876	$19,420

The Director of Clinics is also the head of the State Department of Mental Health. He determines the amount of allocations to each clinic on the basis of number and qualifications of personnel, types and amount

of services rendered, and overhead expenses and equipment.

THE MERIT SYSTEM ORGANIZATION

The three departments that were initially covered were the Department of Public Welfare, the State Board of Health, and the Unemployment Compensation Commission. On December 15, 1948, the Department of Mental Hygiene also came under the merit system coverage. The system is primarily concerned with the maintenance of appropriate personnel standards and the recruitment and selection of qualified personnel and thus provides a sound basis for the employment and development of an effective working force.

In order to make the personnel program work, the operating agencies must follow through with a careful selection and orientation of new employees and have a positive program of employer-employee relationships. Consideration should also be given to effective supervision of employees.

Since salaries have a tendency to become out-dated, a continuous study is made of salary schedules of comparable positions of employers. Because of the general rise in wage levels, a general revision of salaries was adopted by the Department of Mental Hygiene on January 1, 1956. The revision of salaries was the result of the work of the various disciplines of the mental hygiene clinics. The groups clarified job specifications and salaries at their quarterly meeting at the State Hospital at Warm Springs in October, 1956. (This project represented a step forward in attempting to qualify their positions, raise standards and have uniform standards throughout the state.)

The results of the general revision of salaries is as follows:

TABLE X

SALARY INCREASES FOR CLINIC PERSONNEL
ACCORDING TO STATE MERIT BOARD

POSITION	INCREASES EVERY SIX MONTHS				
Board Certified Psychiatrist	$800	$850	$900	$950	$1000
Board Eligible Psychiatrist	700	750	800	850	900
Senior Physician	600	650	700	750	800
Psychologist III	450	($25 steps)		550	
Psychologist II	350	375	400	420	450
Psychiatric Social Worker	300	325	350		
Clerk-Stenographer II	210	220	230		
Clerk-Stenographer I	180	190	200		
Clerk-Typist	175	185	195		

Table X shows the increments for psychiatrists who are qualified to take the Board examinations. At the October meeting in Warm Springs, the psychiatrists employed by the mental hygiene clinics spelled out the qualifications and functions of their positions. The group emphasized that the psychiatrist in each clinic (under the direction of the Director of Clinics) is responsible for directing the activities of the Clinic, and of coordinating the work of the various disciplines within the Clinic. In addition to this particular function, the psychiatrist has the responsibility

1. To cooperate with and integrate the services of the clinic with the local public and private health, welfare, educational and other activities in order to effectively use all local and other resources in achieving the ends and purposes of the clinic; to participate in planning, directing and conducting such research as is indicated; and, to consult with and to provide leadership and information for local community groups.

2. To give professional leadership, encouragment and assistance

to other members of the clinic staff so as to help them develop the highest possible level of professional competence.

3. To direct the psychiatric examination, diagnosis and treatment of persons applying to or referred to the clinic for such services. The psychiatrist is considered to be the only member of a clinic staff who is qualified to make a recommendation regarding treatment of a patient.

4. To utilize, either directly, or through other members of the clinic staff, whatever available community facilities are appropriate for assistance.

5. To direct professional staff meetings, to include case presentations and discussions, and general clinic policy.

6. To make periodic evaluation of the services of other members of the clinic staff and consult with them to help them improve their efficiency.

7. To maintain records of all clinic cases, and

8. To make such reports as may be necessary.

Although the group of psychiatrists outlined their functions in clinical work, the duties of the disciplines should be sufficiently flexible to assure opportunities for experimentation according to the type of community that is being served. It is especially important that the functions of the psychiatrists be spelled out since there is more of a shortage in that area than in any other field of mental hygiene. Also, the efficiency of a clinic program is determined to a large extent, by the standards and policies that are set by the psychiatrist in charge.

Since so much of the success of a program is determined by the psychiatrist, the group at the quarterly meeting recognized the necessity

of having well-qualified people. The qualifications set up by the group are as follows:

1. Graduation from a Class A Medical school, or of its equivalent outside of the United States and completion of at least one year of approved clinical internship.

2. Two years of residence in psychiatry in an approved training center, and one year of supervised training in an approved out-patient clinic. If psychotherapeutic service for children is to be given, there should have been one year of approved training in child psychiatry; or

3. Certification in psychiatry by, or ability to meet training requirements in psychiatry of, the American Board of Psychiatry and Neurology Inc.

According to Table X a psychiatrist who has not passed his board examinations has the same functions as the board psychiatrist, but receives from $50 to $100 less monthly income.

To date there have been no senior physicians who have applied for positions in the mental hygiene program in Montana. However, there are openings for such positions and their duties include professional work done under the general supervision of higher level psychiatrists. The qualifications include graduation from an accredited school of medicine and successful completion of an internship in an approved hospital. The Director of Clinics is hopeful that Senior Physicians will eventually make up for the shortage of available psychiatrists.

Psychologists. The group of psychologists from the four clinics spelled out the distinguishing features of their profession. They emphasized that the work of the psychologist consists primarily of psychological

testing although interviewing and psychotherapy may be assigned to the worker. To perform his necessary functions, the psychologist should be qualified to:

1. Select, administer, score, interpret and report the findings of diagnostic psychological tests and measuring devices, aiding in the study and treatment of problems presented by patients in a Mental Hygiene Clinic.

2. Participate in departmental professional staff meetings, assist in presenting case reports and prepare and present occasional professional papers for discussion.

3. Perform related work as required which might include psychotherapy and research.

In addition to the minimum standards and qualifications outlined for Psychologist I, Psychologist II does consultative, teaching and public relations work. He also does more intensive psychotherapy. His qualifications include internship type experience at a training center approved by the American Psychological Association Training Committee.

The Psychologist III functions more as a clinical psychologist in a psychiatric setting and provides professional leadership and training for other clinical psychologists. His qualifications include a Doctorate of Philosophy in Clinical Psychologist, including a one year's internship in a training center.

At the present time, there are two Psychologists II and one Psychologist I employed in Montana clinics. There are no Psychologists III in the present program.

Psychiatric Social Workers. The representative group of social

workers outlined the functions and qualifications for members of their profession. It included the following:

1. To carry out in accordance with the policies and procedures of the Department the psychiatric social work functions of a Mental Hygiene Clinic through the use of appropriate social casework principles.

2. To assist the department in its educational and community work.

3. To utilize available community facilities.

4. To consult with and give information to the general public in developing understanding and appreciation of the purposes of the state's Mental Hygiene program.

5. To confer with appropriate staff members of public and private institutions in the community such as those engaged in health, welfare, educational, probational and related activities.

6. To participate in department staff meetings, to participate in clinic staff meetings and case conferences.

7. To use psychiatric and social work supervision to increase professional knowledge and efficiency on the job.

In order to perform the functions mentioned above, the minimum qualifications include:

1. Successful completion of one year of graduate training in a recognized school for graduate social work training.

2. Knowledge and abilities needed for successful performance of the work included:

Considerable knowledge of psychiatric and social casework principles; the ordinarily available community resources; emotional development of children; community and family social, economic and mental hygiene problems;

and purposes, principles and methods of modern mental hygiene clinics; some knowledge of clinical use of psychological tests; and of principles of modern psychiatry.

3. Ability to establish and maintain effective and cooperative relations with other employees and with people working in related fields, such as local welfare and public health departments, schools, courts, and law enforcement authorities; to speak clearly and concisely and to plan and execute work effectively.

The qualifications for a Psychiatric Social Worker II include a Master's degree from an approved graduate school of social work with responsibilities that are commensurate with the education. The minimum qualifications for Social Worker III include a certificate showing successful completion of a third year of social work training in a recognized school.

There are at present, three Social Workers II and one Social Worker I in the Montana set-up. There are no Social Workers III.

Procedure. It has been shown that each member of a psychiatric team has his respective duties according to his unique training and experience; nevertheless a "team approach" is used in which clinic personnel collaborate to give patients the best possible service. Weekly conferences are held and the information obtained by the social worker, the test results from the psychologist and the observations of the psychiatrist are given consideration. A patient's illness must be diagnosed by the psychiatrist, before the patient can be seen on a therapeutic basis by other team members. The psychiatrist, with the assistance of other clinic personnel, determine which worker should work with each individual patient.

The procedure in the Montana program has been to follow an "open door" policy which means that residency within a geographic area means eligibility for service. (This policy resulted in a "waiting list" of seventy-five persons in the Butte clinic in 1951 and the three other clinics had lists of varying lengths.)

Because of the pressure of work, no appointments were made for the people on the "waiting list" for over a year. The staff members then decided to "clear up" the list and the people were contacted with the following results:

TABLE XI

THE DISPOSITION OF SEVENTY-FIVE PATIENTS AFTER BEING ON WAITING LIST FOR ONE YEAR

Kept appointments	Letter returned unopened	No answer	Made other arrangements	Worked out own problems
18	8	15	21	13

After the"waiting list" had been in operation for one year, eighteen of the seventy-five people could be contacted or were still interested in services. The remainder of the patients had either moved, were uninterested, had found other solutions to their problems, or had worked out their own answers. Twenty-one people made other arrangements for help. Since the"Waiting list" was depleted in three weeks, it seems probable that the recommendations for patients could be made at the time of the "intake" interview.

Services Rendered. The clinic services can be divided into two

areas, (1) Community Services and, (2) Study and Treatment.

The community services include the education of the lay people in the field of mental health and interpretive talks regarding clinic policy and procedure. The personnel hopes that by long-range planning and education, there will be less mental illness.

At a state-wide meeting held at the state hospital in Warm Springs in 1952, the staff discussed how best to use their abilities considering their limitations in number and in time. The consensus was that the emphasis should be primarily in the field of education rather than in the area of treatment of individual patients. It was felt that "prevention" rather than "remedial" work would have the most far-reaching results in eliminating mental illness. Suggestions were made that group therapy might be a partial solution to the conservation of time in the treatment of patients.

Staff members of the Butte clinic gave interpretive talks regarding clinic policy to such groups as local PTA's, The Junior League, The Silver Bow Medical Organization, the American Association of University Women, the Soroptimist Club, The Active Club, and the Chamber of Commerce. In 1952, staff members realized that some organizations were using their services to "fill-up" a program because a speaker was needed. From then on, the requests to give talks were evaluated on an individual basis and talks were given before only the groups that had an interest in understanding the clinic program.

In addition to giving individual talks, the personnel held conferences with community agencies that requested their services. Each clinic in the state had a program which included conferences with local

organizations. These groups varied throughout the state depending upon the types of agencies and the interest shown within these groups.

The Butte clinic met bi-monthly with staff members of the County Welfare agency, the Public Health Service, the City Council, public and parochial schools. The staff met for two years with the public school personnel before it realized that the group did not want to have conferences. The program was started by the clinic members and the idea was not accepted by the teachers. It was decided that conferences would be held only by the groups that desired the services and could benefit from the discussions. This procedure released time that could be spent on other activities.

The Local Mental Health Society. Partly because of community education, a group of lay persons became interested in organizing a local mental health society. The first and only local society in the state was organized in 1949 in Butte. The society was instrumental in organizing the state mental health society in 1951. The state group furnished leadership in promoting a bond issue to finance a building program at the State Hospital at Warm Springs, and the State Training School in Boulder. The project of the Society for 1957 is the establishment of local mental health societies throughout the state. The professional people in the mental health field will furnish leadership in setting up the individual programs. Between three and four hundred people usually attend the annual convention of the Society.

The Mental Health Society in Butte became inactive in 1953. The clinic personnel felt that it was because they had been too active on the programs and did not allow the lay people ample opportunity for program participation.

Study and Treatment. Although the professional clinic staff is active in community activities related to mental health, most of the staff time is spent in the area of treatment and study.

During the first seven years that the Butte clinic was in operation, over two thousand people had appointments at the clinic. They came from a radius of approximately one hundred miles, and in addition to Butte patients, they included people from Bozeman, Helena, Deer Lodge, Anaconda, and Drummond (in addition to smaller towns).

The children who had clinic appointments represented about seventy-three per cent of the total patient load. They ranged in ages from five to eighteen years.

Study. Approximately two thirds of the total number of patients seen were "studied" only. This group represented people who were not seen on a long-term basis in therapy. They usually had an appointment with the social worker for a case history, one appointment with the psychologist for testing, and one appointment with the psychiatrist to enable him to make a diagnosis of the patient's illness. The doctor then (1) gave direct suggestions to the patient to assist him in working out his problems, or (2) recommended hospitalization, or (3) referred the patient to other agencies. The agencies to which patients were referred the most frequently were schools, churches, physicians, and relatives.

Treatment. The psychiatrist determined which patients could probably benefit from therapy. They were usually seen on a weekly basis by one of the staff members. The goal of therapy was to help a patient obtain insight into his problems so that he could become a more effective individual.

Eligibility for Service. Any person is eligible for clinic services regardless of his duration of state residence. Clinic appointments may be made either through agencies or by individuals. There is no age limitation for applicants. There are available services for all age groups.

There is no charge for services. Individual clinics cannot accept monetary gifts or the money received will automatically go into the general state fund for over-all expenses. On one occasion, the Butte community demonstrated their willingness to contribute toward clinic funds by paying one-half of the salary of the psychologist for one year. The possibilities of using community resources for financial backing has not been explored by the clinics in Montana.

Appointments for interviews may be arranged by telephone, letter or personal contact. The initial appointment is made by the office stenographer. According to clinic records, physicians rank first in the list of referring groups. The number of self-referrals (people who make appointments on their own volition) ranks second. (After the first two years of clinic operation, self-referrals moved from fourth to second place on the list which might indicate that people are acquiring a more positive attitude about psychiatric services.

Policy. There is no written material regarding the clinic policy in Montana. The following points are characteristic of the Butte clinic only, and they evolved primarily by the "trial-and-error method."

1. All patients must be seen by the psychiatrist. No other team member is considered to be qualified to make a diagnosis or recommendation regarding a patient's illness.

2. More than one interview is scheduled when interpretive interviews are held with parents of retarded children. This policy gradually evolved when clinic disciplines felt that more than one interview is indicated to help parents to emotionally accept the problem of retardation.

3. The psychologist determines the type and number of tests to be administered to individual patients; however, intelligence tests are administered to all children who attend the Butte clinic. (The psychiatrist requests additional testing of patients when he feels that it is indicated.)

4. Brief, impersonal letters regarding the diagnosis and recommendations of a patient are sent to the referral source with the exception of schools. Conferences are scheduled with school personnel regarding students so that letters from the clinic will not be on file in the offices of the school.

5. When children are scheduled for therapy, the child and mother have regular appointments with different team members. Several years ago, fathers were also included for appointments and clinic personnel felt that fathers contributed a great deal in helping to work out his child's problems.

6. The original clinic policy was for adolescents to be accompanied to the clinic by the parents (or parent). In 1952, adolescents were given an opportunity to keep appointments exclusive of their parents. (Two years after this policy had gone into effect, the number of adolescents had doubled that made clinic appointments.)

7. Patients with an acute illness were fit into the psychiatrists schedule on an emergency basis without following the usual clinic procedure. This decision is usually left to the discretion of the social worker.

8. A cooperative policy has evolved to have clinic personnel follow-up patients who have been released from the state hospital at Warm Springs.

9. All material obtained from patients is considered to be of a confidential nature and will not be released without the consent of the patient (except in extreme circumstances).

10. Clinic members attempt to have the general policy sufficiently flexible to enable individual members to make exceptions to fit individual and unique situations.

Weekly conferences are held by staff members to discuss individual cases and procedures. Similar matters are discussed at the quarterly meetings held at the state hospital where personnel from all state clinics attend. The various disciplines meet individually to work out mutual problems, and to exchange ideas. The individual groups then meet in a general session to work out overall problems. A social evening is considered an important part of the program.

Report of a Survey by WICHE. The Western Interstate Commission for Higher Education assumed the sponsorship of the survey of the mental health facilities in the western states. Although the results of the study are not conclusive, they indicate general trends and weaknesses. The study was conducted with three main areas explored: Community Services, Research, and Training. (These categories are the ones outlined by the Mental Health Act, 1947.)

The results of the Survey conducted by WICHE show that in Montana there are four unfilled budgeted positions for psychiatrists, five for psychologists, two for psychiatric social workers, and nine for psychiatric nurses. The general estimate is that Montana needs two or three times

as many specialists as are now employed.

The report shows that there are no facilities for advanced training for the three disciplines. There are no plans for training facilities for psychiatrists, for training of psychologists at the Ph. D. level, or for social workers at the Master's degree level. Mental Health personnel and the Montana Mental Health Society are discussing possibilities for training personnel within the state, but there are no definite plans at the present time.

There is one research project at the State Training School, one at the State Hospital and thirteen studies are being carried on by individuals, and that is the extent of the research. The Survey indicated that the thirty-five mental health specialists that answered the questionnaire indicated an interest in research, but the main obstacles were lack of funds, lack of staff time, and lack of personnel. The report stressed the first step toward a successful program of research is to evaluate the need and resources of the state.

The study indicated a discrepancy between the shortage of mental health facilities and personnel, and the need for increased services. The committee recommended that a comprehensive study be made of meeting the demands for services, and of obtaining increased funds to hire personnel.

The committee also recommended that opportunites be made for research and that a coordinated agency integrate the efforts of the state agencies.

CHAPTER VI

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

This study is an evaluation of the strengths and weaknesses of the Mental Hygiene program in Montana. The procedures and policies were discussed from the standpoint of number of personnel, and services rendered. The effectiveness of the program was determined by comparison with other states and by the policies that have proved to be efficient and practical.

The background of the thinking about mental illness was traced from Colonial days to the present time. The contributions of several leaders were outlined and especially the crusade of Dorothea Dix of the seventeenth century. The outstanding leader of the eighteenth century was Benjamin Rush, because he raised the study of mental illness to scientific levels. All of the movements and contributions culminated in the Mental Hygiene movement led by Clifford Beers. The results of the movements eventually were the affiliation of the professions of Social Work and Psychiatry, in the Child Guidance movement and the establishment of prison clinics.

The work of Clifford Beers gave leadership to the passage of the Mental Health Act which provided for financial and consultative service to the individual states in the three areas of Research, Training, and Community Services. The provision of the Act paved the way for the development of many state programs including Montana's program. The effectiveness of Montana's program has been evaluated by some of the major points emphasized in the Act, and by the results of experiments in the two

areas of Study and Treatment.

The major findings of the study were as follows:

1. The results of the survey conducted among the western states by the Western Interstate Commission for Higher Education showed that there are four unfilled budgeted positions for psychiatrists, five for psychologists, two for psychiatric social workers, and nine for psychiatric nurses.

2. Table II itemized factors that might induce professional people into the various states. Fifty-nine and three tenths per cent of the total number of respondents stressed that the physical features of Montana were appealing to workers.

3. The second item that was marked on Table II showed that 22.2 per cent of the respondents find their jobs challenging in Montana.

4. The third item marked showed the 19.4 per cent of the respondents felt that there were pleasant living conditions and inexpensive living in the area.

5. There were no responses that "There is an active professional group in operation in the state."

6. In Table III, which suggested changes to interest workers, the item marked most frequently was that salaries are inadequate in the program.

7. The second item marked according to frequency was that there should be more opportunities for training. Thirty-eight and seven tenths per cent of the specialists answered that item.

8. The item suggesting that state personnel policies should be improved was marked by 25.3 per cent of the respondents. This item included retirement and the merit system.

In accordance with the three areas outlined in the Mental Health act, the results of the survey will be discussed in those three fields, (the points that have been outlined present some feelings about the total program).

Research. The Survey showed that 1,420 specialists are engaged in eight hundred eighty three research projects and that there is interest in carrying out three times as much research.

The largest barrier for research in Montana is the lack of funds as indicated by 63.0 per cent of the respondents who answered the item. Other barriers that were mentioned were professional people who are not motivated for research, and the fact that professional people feel their work is too time-consuming to work on projects.

Community Services. The Survey attempted to show the extent of present facilities and ways in which they could be expanded.. The item in the Survey that was answered by the most agency directors was that there should be more specialists in the state, and that the services were inadequate. (There were not items marked which gave insight into the ways in which service was not satisfactory.)

The school administrators felt that they were unable to hire the necessary specialists because of a lack of funds, trained personnel, and lack of public support.

Tables V and VI showed that private psychiatrists in Montana (four in number) felt that there are not enough specialists and that the service is inadequate. This thinking was the same as the school personnel and the agency directors.

Training. The Survey pointed out that one reason for the shortage

of personnel is the lack of training centers.. In Montana there are no training facilities for professional people (with the exception of a two-year Master program in Clinical Psychology at Montana State University).

Table VII showed that private psychiatrist believe that physicians could be trained in the "whole man approach" to give more effective help to patients with emotional problems.

Although the results of the survey were inconclusive, at least it opened up the avenues for future study and research.

The study has showed the thinking of professional people about the needs and possibilities for mental health programs. Consideration was also given to important points for the efficient function and organization of clinic programs and the important points are discussed below.

Clinic Planning. Various studies of clinics have indicated that the first step in organizing a clinic is to have an organizing group of people made up of community representatives.

Before the clinic is organized, a survey should be made of the community resources and needs. The goals and functions of the program can then be formulated.

After the initial stage of organization, the staff should be obtained and should consist of people well-qualified for their positions (according to the standards of their professional groups).

The second step should be the working out of financial backing. Consideration should be given to the estimated cost of $37,000 yearly for operation, and sufficient money to operate for a three year period. The organizing group must know that local groups must ultimately be responsible for the permanent financing, even though national funds are

used to start new programs.

In order to finance a clinic, "fee charging" should be given consideration and should be sufficiently flexible to waive payment for those who cannot afford to pay for services.

The study pointed out that in addition to clinic financing, the "intake policy" should be considered whereby individuals are referred by professional sources and the referring sources must contact the clinic for a discussion of the patient. Some experiments have shown that much valuable clinic time and money is saved by eliminating some poorly motivated patients. This policy has been successful in the experiment carried on in Prince George's County Mental Health Clinic.

The study also emphasized the use of traveling clinics to give services when they might not otherwise be avilable to some areas.

In addition to pointing out some of the weaknesses of Mental Hygiene programs, the study gave a resume of the present program in Montana from the organization standpoint. The state Merit System was used as a criterion for evaluating the standards of the various disciplines. The types of services rendered were discussed in the areas of Community Service, and Study and Treatment.

CONCLUSIONS

The conclusions of the study have been based upon an analysis of the Mental Hygiene Program in Montana. The analysis has been made by studying the state program in the areas of Research, Training, and Community Services. The effectiveness of the program has been analyzed by the results of the findings of the Survey conducted by the Western Interstate Commission of Higher Education, and also by determining which workable

policies and procedures might improve the present program.

Based on the assumption that there will never be sufficient personnel to meet the needs for psychiatric services, the study concluded that there are ways the program might be reorganized. The study pointed out that since the "open door" policy has resulted in "waiting lists" the Montana program should be re-evaluated from the standpoint of Organization and Intake policy. The policy of screening patients during the "intake interview" of using "traveling clinics" and of "fee charging" offer solutions for helping the limited number of personnel to meet the demand for services.

The conclusions of the study were that offering more adequate salaries, capitalizing upon the scenic and recreational possibilities of the state, and of having a strong professional organization might be of value in encouraging more workers to come to the state.

The study also pointed out that there is a need for research to determine whether the emphasis should be on education, or study, and treatment in regard to clinic programs. Since the mental health programs have developed into a coordinated state and federal program, there is a need for studies regarding the functions and goals of the program.

RECOMMENDATIONS

The recommendations for improving the effectiveness of Montana's program are based primarily upon experiments that have been conducted, and upon the results of the survey of the Western Interstate Commission of Higher Education; however, some of the recommendations are from observations of the writer while working in a clinic and from suggestions of clinic personnel and patients.

Community Services. The "open door" policy resulting in "waiting lists" indicates the need for the formulation of policies at the organizational level. In organizing future clinics, the ground work should be done by an organized group of pagency representatives who "spell out" the functions, goals, and limitations of a clinic program.

The "open door" policy (resulting in seventy-five persons on the list in the Butte clinic at one time) points out that patients should be screened by professional people within the community who understand the function of the clinics.

Since there is a shortage of trained personnel in Montana, possibly "fee charging" and the screening of patients at the "intake level" might be partial solutions to the problem since these policies have been successfully tried in other states.

Since more respondents checked the item of "attractiveness" of the state than any other item on the questionnaire, it is probable that the scenic beauties of the state should be capitalized upon to interest workers in coming into Montana to work.

The arrangements for conferences with agencies should be carefully evaluated and the desire for conferences should come from the agency. (For instance, much clinic time was wasted in Butte with resultant antagonism when the clinic personnel met with school personnel for two years when the schools did not want the conferences.)

The entire clinic staff has attended most conferences and community meetings. It would probably be more practical if one team member represented the clinic and the other two members carried on their respective duties.

The emphasis of the program should be toward short-term therapy.

For instance, eleven patients who had a poor prognosis for treatment were seen in therapy over a two-year period of time resulting in considerable time and expense.

Clinic personnel should act in an advisory capacity in helping lay persons in organizing local Mental Health Societies. For instance, the local society in Butte became inactive partially becuase the members did not have ample opportunity and training in program participation.

Each clinic has formulated individual policies which has resulted in lack of organization and a lack of standardization of recording. There should be written policies of the overall program which has been approved by state personnel.

Research. The Survey of Western States facilities indicated that the Mental Health specialists are hampered in their attempts to conduct research by lack of funds and available time. There should be more emphasis in the Montana program toward research by attempts to obtain fellowships and stipends. (The provisions of the Mental Health Act make scholarships available to people who desire to study in the field of mental health.)

There are no regular funds provided for traveling to out-of-state institutes and workshops. If clinic personnel had ample opportunity to attend conferences, it is probable that they might become more active in research and organization.

In Montana there is no strong professional organization which could guide people in the areas of research and community planning. Consideration should be given toward encouraging staff personnel toward becoming active in their professions.

Training. The only opportunity for advanced training in Montana is the new two years' Master's program in Clinical Psychology which will start in September, 1957, at Montana State University.

Although the study indicates that there are changes which will improve the standard of services rendered through the clinic program, there are many encouraging facts about the organization of the present set-up.

The clinics follow a multidiscipline approach which gives the patient the benefit of a combination of a variety of training and experience.

The program is centrally administered with the Superintendent of the State Hospital as the Director of Clinics. He is a psychiatrist and therefore oriented in the field of mental health.

The use of "traveling clinics" in the Missoula and Billings clinics indicates that the personnel is attempting to use various methods of meeting the problems of personnel shortage.

The clinic program is publicly supported which indicates that the problem of mental illness is recognized as a public health problem in Montana.

Consideration is being given to obtaining and keeping trained personnel in the state as indicated by the increase in salaries in the Merit System standards in 1956.

Much positive work has been done by clinic personnel in the areas of treatment and public relations which is shown by the statistics that self-referrals are second in the "source of referrals" with physicians being first.

Perhaps the most encouraging factor regarding the clinic program is

the result of the quarterly meeting of clinic personnel in October, 1956. At that meeting, the members of the various disciplines formulated the qualifications and functions of their individual professions. This was the first state-wide step toward standardization and should do much toward clarifying policies and eliminating some of the overlapping of services among the disciplines.

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